THE HISTORICAL AND THEOLOGICAL IMPLICATIONS IN THE TREATMENT OF MENTAL ILLNESS (WITH SPECIAL REFERENCE TO SCHIZOPHRENIA)

by

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DISSERTATION ABSTRACT

Purpose

The writer's purpose has been to find an effective mode of therapeutic intervention for schizophrenic clients. A historical overview in Chapter I gave a look at the attempts of church and society to discover and deal with the causes of mental illness in general. In an effort to discover a plausible theory of causation Chapter II examined current biological, psychosocial and sociocultural research theories and findings. Chapter III was dedicated to the search for a theological rationale which would prove helpful to both client and counselor in the therapeutic setting. In order to isolate one or more effective clinical treatment modes Chapter IV concentrated on a variety of approaches to therapy, both historical and existential, which are most commonly in use today by therapists in general and by the writer in particular.

Procedure

The requirements of this dissertation have not mandated the use of depth research with control groups; rather, the writer has drawn extensively upon the available literature in the field of mental illness and leaned heavily upon research done by recognized leaders in the field of psychotherapy. Factual and observational material gleaned from the writers own therapeutic relationships with several clients in a clinical setting were used.

Conclusions

1. No one clinical entity can be isolated as the cause of schizophrenia. However, studies indicate that a mixture of organic and psychological factors are involved.

2. Schizophrenia cannot be treated successfully with the medical model concept in which this condition is treated as a biological illness. The most effective treatment mode combines the use of chemotherapy and psychotherapy.

3. Society throughout the history has been baffled with the phenomena of mental illness and, in its frustration, has treated the mentally ill with fear, hatred and rejection.

4. The schizophrenic has experienced deep emotional impoverishment, more often growing out of early familial dysfunctional relationships. This condition has produced a low level of self-worth and self-acceptance and a feeling that the person is not at home in this world.

5. This kind of person will deal with his defenses best when he can feel acceptance and worth as an individual.

6. The New Testament, through the theological teachings of Paul, the Apostle, and the teachings and life-demonstration of Jesus, the Christ, tell of the unconditional love and forgiveness of God, a free gift that cannot be earned or worked for. "You are accepted as a Child of God in spite of everything."

7. The most effective talk-therapy is based on the growth model formula: acceptance (caring) plus confrontation equals growth. The counselor/therapist who radiates non-possessive warmth, accurate empathy and genuineness will most easily help the client to sense the acceptance which will permit confrontation and ultimate growth in mental health. The growth model is an affirming and positive method which builds on the relationships between client and counselor.

INTRODUCTION

This study evolved out of my last two years employment at a mental health clinic and two psychiatric hospitals while, at the same time, continuing an academic and practicum program leading to graduate degrees in marriage and family counseling. For thirty years my vocational pursuits have centered around the parish ministry and navy chaplaincy and has included a continual interest and involvement in mental health concerns and an active counseling program. This backdrop of personal experience and interest will perhaps help the reader to understand better the reason for this study.

Obviously no one book nor even several volumes could include all the necessary information concerning mental health, mental illness or the ramifications of a treatment modality for schizophrenia. Consequently I have chosen in this paper to show how society has been trying desperately to explain and cope with mental illness and to briefly document the continual struggle that has been waged in almost every historical era to determine the cause of mental disturbance and to show in particular that schizophrenia does not generally respond to the typical "medical model" of intrapsychic therapy but responds more readily to a combination of chemotherapy and talk therapy. The requirements of this assignment have not required the use of depth research with control groups; consequently I have drawn upon the resources from extensive publications in the field of mental health and used factual material from my own therapeutic relationships with a number of persons at the clinic who have the symptomatic characteristics of schizophrenia.

Chapter I gives a broad sketch of attitudes experienced from society by the mentally ill through the centuries of recorded history. The several million years before Christ, through the classical era of Greece and Rome to about A.D. 500 leaves the observer quite encouraged about the treatment of the mentally ill. Viewing the years that followed the fall of Rome brings despair. During the 2000 years known as the Dark Ages there are continual accounts of bestial cruelty, abysmal fear and rampant superstition which governed much of society's attitudes toward the mentally ill who were branded as witches in the 13th century and treated by torture and persecution. Many of society's difficulties were easily laid at the doorstep of a man, woman or child who was considered to show aberrant behavior. Although the 16th century witnessed the burning of about one million persons for witchcraft, the Renaissance and Age of Reason brought new strides in mental health, not only from the stirrings in medical fields, but also from social and political movements. The smothering authority and domination of the church was considerably minimized in the fields of medicine and social sciences also. Various forms of "moral therapy" developed through the compassionate efforts of men and women who were shocked at the treatment of the mentally ill, yet who endured derision and criticism for efforts expended toward this hopeless category of humanity.

In Chapter II a specific psychosis known as schizophrenia is brought into sharper focus; leading all general and mental diseases as the cause of hospitalization it is classified as the world's greatest disease. Descriptive data on this mental condition is presented alongwith biological, psychosocial and sociocultural factors felt to be

prominent in the development of this condition. The diagnostic dilemma surfaces when evidence is presented to show that theory, method and nomenclature of the past does not fit into the existential knowledge and treatment of schizophrenia; in addition there appears to be a bias in diagnosis and treatment among the social class structures of society.

Chapter III presents a theological base for the understanding and treatment of schizophrenia: namely that a person's spiritual experience of the regenerative potentials of the presence of God in the inner space of one's being is an important element in building an awareness that that person is not alone, alienated or unacceptable. This understanding of the selfless, forgiving love of God that cannot and need not be earned becomes the basis for the divine-human encounter that helps one to accept himself as worthy and finally to trust and accept others without fear and judgement. A major theme running throughout this chapter and into succeeding chapter maintains that caring and acceptance are the basic ingredients for good mental health and are necessary before personal growth can occur. The life and ministry of Jesus and the theology of St. Paul constitute the major thrust for this understanding and also provide important guidelines for the counselor as he/she participates in the divine-human encounter of therapy.

Chapter IV centers around the current inpatient and outpatient treatment for persons with schizophrenia. Of the several different treatment approaches available today the combination of chemotherapy-psychotherapy is explained in detail as the most currently effective method. The growth-model concept of talk-therapy is singled out as the one which most nearly meets the needs of the schizophrenic person and more closely resembles the formula for growth as noted in Chapter III.

Some suggestions are given regarding self-care for the client as well as a case study of a client of the writer which illustrates the growth-model treatment mode. Finally, some potent areas of research are suggested as immediate and long-range objectives for the future along-with some warnings to practitioners and families regarding the care of the schizophrenic person.

CHAPTER I

HISTORY OF MENTAL ILLNESS

The history of schizophrenia, in a sense, is the history of behavior pathology itself, because its symptoms were already recorded and differentiated from other abnormalities more than 3300 years ago.[1] Despite its long history, it remains among the most bewildering of psychotic disorders and is still not well understood.

Im primitive cultures those who had mental illness were thought to be possessed by evil spirits and demons and were accused of bringing the wrath of the gods upon them and the family. Persons have always attributed to the supernatural that which they cannot explain. Evidence of this supernatural power was seen in storms, lightning, earthquakes, flowers, trees and objects. These spirits, both good and evil ones, controlled the destiny of all people and they felt powerless over these forces. Primitive people, as today, took credit themselves for the successes they enjoyed, but blamed their misfortunes upon the supernatural. It was only natural, under these conditions, that mental illness, which was unexplainable and frightening, would have been thought of as the result of evil spirits residing within the individual afflicted. It was necessary to get that evil spirit out of the body, even if it meant splitting the skull, exorcism, torture and pain. Priests, medicine men, or witch doctors were given the responsibility for all diagnoses and treatment.

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[1] P.H. Hoch and J. Zubin (eds.) Psychopathology of Schizophrenia (New York: Grune and Stratton, 1966), p. 92.

The earliest records tell of a priest-physician, Imhotep of Egypt, who was an advisor to Pharoah's family at about 5000 B.C. and who was called the father of mental and spiritual healing. He became known as a demi-god and was gradually removed from the status of humanity because it was believed he visited suffering people during their sleep to heal pain and disease; this was probably the first example we have of the healing that can occur during sleep. People slept in the temples because the god or goddess effected cures or prescribed remedies to the sick while they dreamed within the temple walls. The priest-physician prepared the minds before sleep by lectures and whispered suggestions in their ears in the name of the god or goddess.

In ancient Greece, people went to temples to be cured of sickness through purification, such as bathing, sacrifices, herbs and religious ceremonies. They also practiced incubation in which the patient was put to sleep and dreamed of his illness; when awakened, the person was reportedly cured.

During the 6th century B.C. philosophers such as Heraclitus and Protagoras succeeded the priests and witch-doctors in history as the knowledgeable persons in the area of emotional problems and physical disorders. In the 4th century B.C., however, a physician name Hippocrates observed and described several mental disorders that are now known as delirium, mania, post-partum psychosis, melancholia, paranoia and epilepsy. He argued that mental illness was not the result of supernatural possession but rather that it proceeded from natural causes; he was the first in the Golden Age of Greece to use gentleness and kindness with the mentally ill. Somewhat later, Plato taught that

persons with emotional disturbances were not responsible for their acts, and another philosopher, Aristotle, rejected psychological causes for mental illnesses and insisted that man's mind was immortal and incapable of being diseased.[2]

One of the earliest Roman physicians, Asclepiades, during the second century B.C. described hallucinations, illusions, delusions and distinguished between them, although those specific terms were not used. He devised treatments utilizing diet, pleasant surroundings and some hydrotherapy.

Early A.D.

Fear of evil spirits supposedly resting in the mentally ill was shown by the treatment given them in the first century A.D.: bloodletting, purging, starvation, beatings and containment by chains. In every era, however, there were some who tried to treat the mentally ill with humane compassion. It is interesting to note that the benefactor became a person not to be praised but to be avoided, for it made people uncomfortable if someone treated the mentally ill in any other way than by the accepted means for that day. Jesus of Nazareth is a prime example. In a Bible story placed in Luke 8:26-37, the writer tells of Jesus being responsible for casting out the demons from a man. Jesus was forced to leave, however, after relieving the demoniac of his malady. People looked at Jesus and saw a power they couldn't understand. He was one of the few in his day who treated persons like the

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[2]The writer has relied heavily upon the history of mental illness as reported in Merrill T. Eaton, Jr. M.D. and Marge H. Peterson, M.D., Psychiatry (2nd ed. Flushing, NY: Medical Examination, 1969), pp. 507-512.

demoniac with compassion, understanding and courage. As we will be shown later in this chapter, the contagion of his humane spirit carried over into lives of people who lived hundreds of years later.

A first century A.D. leader named Soranus became a protagonist for the mentally ill when he opposed their inhumane treatment and suggested that the patients be treated according to their individual needs and backgrounds. He didn't believe in using purges and hypnotics which were then common. He suggested instead, properly balanced diets and pleasant, comfortable surroundings and freedom from irritating or exciting interpersonal contacts.[3]

Medicine, and especially psychiatry, was appropriated by religion, superstition and magic in the second century A.D. This brought little change to the mentally ill since there were no facilities set aside for non medical maladies until the fourth century, when a few general hospitals assigned special wards to care for the emotionally disturbed. The first hospital for the mentally ill was built in Jerusalem in the fifth century.

Dark Ages

The Dark Ages was a period of regression for the mental health movement in the west as it was for other areas such as the church, society and government. Astrology, Alchemy, demonology and sorcery became the medical sciences in these difficult years due to the church's prohibition against professional medical practices; treatment of mental illness was by exorcism, by influence of saintly relics employed by

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[3]Felix von Mendolssohn, M.D. This is Psychiatry (New York: Watts, 1964), p. 1-13.

religious leaders and by incantations and magic of the sorcerers. Belief in witchcraft and demonology spread throughout Europe and remained long after the Renaissance period.[4]

Medieval society was dominated by the church. Consequently any behavior which was deviant from the church's belief or teaching was considered heretical; any conduct which differed from the normal, either by falling below or surpassing existing standards,was subject to discipline because it constituted a threat to the ruling herirarchy. Demonic possession and madness was one way of explaining the so-called heretical behavior or ideas of the faithful. Beliefs that led to witch-hunts existed long before the 13th century but at that period of history, European society, motivated by the church, used witchcraft as a foundation for the organization of the Inquisition Movement under the ruse of protecting society from potential harm from the witches. Pope Innocent VIII proclaimed, in 1484, that "in parts of north Germany some of both sexes are straying from the Catholic faith, have abandoned themselves to devils." The witch was the dangerous element: the inquisitor was society's protector.

To even question the existence of witches was heresy and constituted a practice of witchcraft. Women, particularly midwives, were chiefly addicted to evil superstitions because all witchcraft was purported to come from carnal lust which was insatiable in women. And men were protected from this crime because Jesus was a man. It was a religious-scientific theory of male superiority, justifying the persecution of women as members of an inferior, sinful and dangerous class

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[4]Eaton and Peterson, p. 507.

of individuals. The Dominican priests recommended physicians as the expert diagnosticians because they could distinguish more easily the diseases due to natural causes from those due to witchcraft. Physicians and priests were much concerned with the differential diagnosis between the natural and demonic illnesses.

The Pope then commissioned two Dominican priests, Kramer and Sprenger, to spread the word about their belief in witches, methods used to determine who was guilty of witchcraft, and to outline the disciplines of torture to be meted out to the guilty. A book, The Witches Hammer, is a classic source for information concerning the witch-hunt of those days. One author stated the belief that "there are such beings as witches which is so essential a part of the Catholic faith that obstinately to maintain the opposite opinion manifestly savours of heresy." (p. 8 Szasz) Many of the accused witches were mentally ill. (The persecution of witches became a religious duty following the Biblical words in Exodus 22:18 "Thou shalt not suffer a witch to live.") The 13-14th centuries were marked by mass psychotic movements that terrified the church because it had lost control. (p. 100 Szasz)

As western medicine declined, progress in investigation, description and treatment of mental illness continued in the Near East until about the 11th century. Mental illnesses were described in detail and treatment was more humane than that of European countries. Many hospitals were founded during this period in the Near East: in Bagdad, Cairo and Damascus. In Europe, mental hospitals were founded in Metz and the people of the village of Gheel in Belgium began caring for the mentally ill in their homes in the 12th century.

Sixteenth Century

Opposition to the mainstream of thought on witchcraft and demon possession began to surface during this period. Juan Vives, a Spanish scholar, emphasized the need to understand the workings of the mind and the importance of the emotion in such processes as remembering and forgetting. His description of the forces operating within persons were somewhat akin to those of Freud nearly three centuries later.[5] Best of all, he recommended kindly treatment of the mentally ill and seemed to prepare the way for others, such as Johaan Weyer, a student of Cornelius Agrippa, who was persecuted for his opposition to the torture of suspected witches and who was profoundly unpopular and disliked. Weyer became known as the first clinical psychiatrist opposing popular beliefs in demonology, and he tried to educate the populace about the illness of those accused of witchcraft, and insisted that they should be treated as ill. He was bold enough to speak about the monks who used torture to obtain confessions from those suspected of witchcraft, and declared that the symptoms shown by the so-called demon-possessed could result similarly by ingestion of drugs like opium or bella donna.[6] He suggested that separation of people with hysteria would prevent spreading of the condition; clinical examinations made by Weyer are descriptions of a condition somewhat akin to schizophrenia. There was opposition again; Jean Bodin, who later was known as the founder of legal medicine, contested Weyer's stand, saying that Weyer

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[5]Manuel F. Pearson, M. D., Fundamentals of Psychiatry (2nd ed. Philadelphia: Saunders, 1968), p. 1-5.

[6]Eaton and Peterson, p. 508.

was interfering in theological and legal areas and should confine his interests to the medical field.[7]

The witchhunt spread from the continent to England. Reginald Scott denied that witches existed and called them imaginary conceptions. King James II,who commissioned the translation of the Bible into English, made strong denunciations against witchcraft, mainly because he felt he had been bewitched himself several times when sudden storms arose and forced cancellation of some sea voyages at the last minute. He looked for the guilty witch and had Dr. Fian, a Roman Catholic, arrested along with a large group of his Roman Catholic admirers. The King was Protestant. Fian was arrested and tortured, confessed and recanted; finally he and several women were burned at the stake. Even the leader of England's strongest Protestant sect, John Wesley, made the startling acclamation in 1768 that "giving up of witchcraft is in effect giving up the Bible."[8] Although several clergy tried to refute the claims at great personal danger to themselves, the prevailing belief was that Christian faith was dependent upon a belief in witchcraft.

Witchcraft prevailed meanwhile in colonial America, reaching its peak in the 17th century in the famous Salem witchcraft trials. A prominent clergyman of the day, the Reverend Cotton Mather, was one who encouraged witch-hunting. He wrote a book about the instances he he seen and heard where "a witch could inflict a person with diseases of astonishment, fits, epilepsy, torments, distemper and pain."

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[7]Ibid.,p. 508.

[8]Robert H. Felix, Mental Illness, Progress and Prospects (New York: Columbia Union Press, 1967), p. 19.

There were some who doubted the rightness of this movement, such as the Reverend George Burroughs who was the respected pastor of Salem Village church before his retirement. From his home in Maine he wrote and spoke against witch-hunting, which made him suspect as being in alliance with the devil along with the victims of his witchery. Burroughs was arrested and brought back to Salem for trial where he was interrogated by lawyers and clergy. Some townspeople showed reluctance to have the retired minister hanged for this offense after such meritorious service to the community but the Reverend Mather quieted the crowd by explaining that the Reverend Burroughs was not an ordained minister and that the devil oftentimes disguised himself as a saint. This was sufficient explanation to convince the onlookers and Burroughs and several others were killed by hanging. A change of attitude among townspeople was noticed, however, as children began to grown and mature into adults and confessed to man untrue accusations they had made about the appearances of witches to them in their earlier years.

Thomas Willis went into the dungeons housing the mentally ill and, from this research and observation, he developed a classification of mental disorders (acquired, congenital, hereditary). At the same time others continued the advocacy of harsh treatment of the mentally ill because they felt the general paralysis of the insane was a disease entity. Such a malady among women was considered for centuries to be a "wandering of the uterus" until Charles Lepois proposed that the cause of hysteria was in the brain and emotions and not in the uterus. Among the ignominious aspects of society's treatment of the mentally ill was the performance provided for the citizenry of London by the

hospitalized persons at Bethlehem Asylum; it was around this institution that the term "bedlam" came to be used, a popularized pronunciation of Bethlehem and referring to the wild, disorganized activities of the patients in that hospital.[9]

Eighteenth Century

The movement upward toward better understanding of the mentally ill reached a good momentum during this era, when men such as George Stahl began to emphasize the relationship of mind and body, and divided mental illnesses into mental, emotional, or physical origin. He noticed the interaction that occurred between the mind and body, such as when vomiting occurred after an emotional trauma. Over three hundred pages were filled with the classifications of mental illnesses, and the term, neurosis, may have had its first usage during this time by William Cullen in Scotland.[10] Jean Columbiere, a physician protested the lack of public interest in the mentally ill, and the vile living conditions and lack of treatment accorded them, particularly when they were being housed in general hospitals and jails for years, along with paupers and general prisoners.

Physicians in other countries began to demand more humane treatment of the insane. William Tuke, in England, a Quaker layman, founded a model hospital providing humane care, and called it the York Retreat. He insisted that patients should have personal attention, good living conditions, and freedom from any mechanical restraints. The establishment of the York Retreat was the culmination of the battle

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[9]Ibid., p. 17.

[10]Pearson, p. 509.

against brutality, ignorance, and indifference. Yet, Tuke was not accepted by the citizenry of that time. He complained that "all men seem to desert me."[11] Demonolgy was cemented deeply in the mind of society, not to be overcome overnight.

Johann Reil, a neurologist, contributed research information showing the anatomy of the cerebellum, and concomitant facts describing emotional disorders. He has been credited with the organization of the term, "psychiatry." His treatment method included a non-injurious torture, such as throwing patients suddenly into water, firing cannons, arousing anger and disgust; all of this was to shock the patient back into reality. In France, Joseph Doquin was suggesting that the mental hospital could be used for treatment and research, not just for confinement, and he also advocated moral treatment of the insane.

Dr. Philippe Pinel became known during the French Revolution as a dedicated physician, and registered his shock at the terrible hospital conditions; as chief of the medical service he ordered all mental patients released from chains, including the general incarcerated prisoners as well. This was no small accomplishment when one considers the political turmoil of those revolutionary days. Pinel is remembered for his hospital reforms, and many hospital facilities have been named after him. When a fellow Frenchman, Anton Mesmer, began treating emotional disturbances by touch and hypnotic trance, there was a general affirmation by the patients, but criticism from his peers. He had his greatest successes in curing hysterial illness.[12] Hypnotism became

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[11]Felix, p. 19.

[12]Mendolssohn, p. 15.

more popular as a therapeutic tool through a neurologist, Dr. Charcot, who also was famous for his therapy with patients with hysteria syndrome. A process of character-reading was also used during this period, and it came to be known as phrenology.

Colonial America

During this time in America there were no hospital facilities available for the mentally ill.[13] The first American hospital devoted to them was the Eastern Lunatic Hospital, opened in Williamsburg, Virginia in 1773. Pennsylvania Hospital was honored when one of its staff members, Dr. Benjamin Rush, was a signator to the Declaration of Independence and was later called the father of American psychiatry. He treated patients kindly and insisted upon clean living conditions. Through his genius, such innovations as the gyrator and tranquilizer chair came into use, as well as work, exercise and amusement, as a part of therapy. Segregating the mildly ill from the more severaly ill helped patients and staff alike to experience a more effective environment.[14]

Nineteenth Century

During this period there were noteworthy advances in psychiatry, particularly in France. It is also interesting to observe again how one man's influence can radiate through other people's motivations. A student of Pinel, Jean Esquirol, introduced the term "hallucination" for the first time, and became interested in criminal psychology, helped to

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[13]Albert Deutsch, The Mentally Ill in America (2nd ed. New York: Columbia University Press, 1949), p. 8.

[14]U.S. Public Health Service "Mental Illness and its Treatment, Past and Present," p. 6 (undated).

establish ten new mental hospitals, and helped put France at the forefront of humane treatment for the mentally ill. His own pupil, Ferrus, established a farm where patients could do occupational therapy. John Conolly urged abolition of all mechanical restraints, which stirred a huge controversy in Europe and America, even though some innovations of this nature had taken place earlier. But, from the campaign reforms of Conolly and Robert Hill, came the beginning of the "open door" system, to give patients freedom to move around in the hospital, and later in the community.

In Germany, Dr. Griesinger was teaching that all mental disorders were a physiologic dysfunction of the nervous system while a Belgian psychiatrist, Benedict-Augustin Morel, named the condition which we now call schizophrenia as démente précoce. Somewhat later another German psychiatrist, Emil Kraepelin, wrote about dementia praecox and distinguished three major kinds of this disorder -- hebephrenia,paranoia and catatonia; his classification, with a few modern additions, is still being used today. These will be discussed more fully in Chapter II, Kraepelin maintained that there was no cure for dementia praecox, and those psychoses which resulted in remission were really manic-depressives and were never truly dementia praecox.

Eugene Bleuler, a famed Swiss psychiatrist who added a fourth form of dementia, the simple type, coined the term, schizophrenia, in 1911. He understood the disorder to be organic,which caused a "splitting" of the mind or personality.[15] Another spin-off from an earlier leader in the mental health movement, Dr. H. Tuke, was a descendant of the Quaker

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[15]Benjamin Kleinmuntz, Essentials of Abnormal Psychology (New York: Harper & Row, 1974), p. 261.

layman in England who founded York Retreat. This man became the first physician in the Tuke family and wrote a history of mental illness as it pertained to the British Isles.

In Russia, Dr. Pavlov influenced the future course of Russian psychiatric thought by his work on biological conditioning, while a fellow countryman, Dr. Korsakoff, was describing the results of chronic alcoholism. An American school teacher, Dorothy Lynde Dix, went to England where she met another member of the Tuke family, Daniel Tuke, through whom she became interested in the mentally ill. When she returned to America, she effected changes in the intolerable conditions in the alms houses and jails housing the mentally ill and spent the rest of her life campaigning for reform in the care of the insane, helped to flund thirty mental hospitals in the United States, opened two large institutions in Canada and completely reformed the asylum system in Scotland and several other countries.

The progress of the mental health movement in this century was demonstrated by the formation of the American Psychiatric Association in 1844 when thirteen superintendents of mental hospitals met together to discuss their mutual problems; mental illness began to be on the same footing as physical illness. Mystery,fear, and ignorance began to give way to a more enlightened perception of emotional disturbance.[16]

This period produced what has been referred to as "moral therapy" which had its motivations mostly from Pinel and Tuke, who maintained "that most of the insane were essentially normal people who

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[16]James Coleman and William Broen, Jr., Abnormal Psychology and Modern Life (4th ed. Glenview, Il: Scott Foresman, 1971), p. 42.

could profit from a favorable environment and some practical help with personal problems."[17] Records show that during the early 19th century when moral therapy was the sole method of treatment, 70 per cent of mental hospital patients, who were ill for less than one year, were discharged as recovered or improved. Some recovery rates were as high as 80 - 90 per cent.

This concept appeared to be effective but, despite this impressive record, the moral therapy movement declined during the last half of the century because of a deep seated conviction that physical medicine was more scientific than psychological medicine, until Freud, most psychiatrists felt that mental illness was caused by a malfunction of the body. This is dramatically shown by the extensive research done with the disease of general paresis, which was found to be caused by syphillis, and was the first time that medical science had conquered a mental disorder. Because paretic patients became psychotic in much the same way as a schizophrenic, it bolstered the idea that mental illness had an organic base. Postmortem examinations showed that paretic patients had damage to brain tissue and nerve tissue, causing abnormal speech and behavior. Sixty-five per cent of paretic patients had syphillis, while only 10 per cent of other mental patients had it. This brought new convictions that similar infectious agents were the root causes of mental illness.[18]

Kraeplin isolated two major mental illnesses as manic-depressive physchosis and dementia praecox, now known as schizophrenia. But no

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[17] Ibid., p. 43.

[18] Paul Mussen and Mark R. Rosenzweig, Psychology, An Introduction (Lexington, Mass: Heath, 1973), p. 232.

physical disorder was found, then or now, to explain these two disturbances, at least, not as seen in general paresis. This could be one reason for the decline of the moral therapy era and for the management of the mental hospitals being placed under the administration of medical personnel, because there was a strong feeling among psychiatrists that the breakthrough had occurred; that mental illness had finally been proven to have its origin in the physical body. There was renewed insistance upon viewing insane people as physically sick people. Though it was now better understood that these persons were not possessed by demons, it was expected that they were not able to meet normal expectations, to do work, to make decisions, and were more or less helpless. It was assumed that the new techniques of physical medicine would be more scientific than the psychological, and that treatment of physical and mental symptoms would be the same. Superintendents of mental hospitals, who previously had been from the moral therapy discipline, were replaced by professionals following the medical model. Recovery rates declined and hospital care became progressively worse as the ratio between patients and treatment personnel got out of balance;all patients were treated as being physically ill; the moral therapy movement which had established that there needed to be one to one relationship with patients showing emotional illness was in disrepute. Mental hospitals were again used as "storage bins" for the mentally ill and it was not until more recent years that methods were again used to treat the individual as a normal human being.[19]

Augmenting the contribution of Dorothy Dix was that of Clifford Beers, a Yale graduate who experienced a mental collapse and was

[19]Mendelssohn, p. 19.

hospitalized in three institutions; he received inept treatment and finally made a recovery in the home of a hospital attendant. The vivid description of his experiences in a strait jacket, how the immobilization of his arms brought increased excitability to an overwrought mental patient, was instrumental in the reform movement. It was through Beers, psychologist William James and Dr. Adolph Meyer, the dean of American Psychiatry, that the contemporary mental health movement got its momentum.[20]

Nineteenth-Twentieth Centuries

The foundation for psychoanalytic therapy was laid late in the nineteenth and early twentieth centuries by men who studied with Charcot and Bernheim.[21] Sigmund Freud, a neuropathologist from Vienna, and Josef Breuer formulated theories of unconscious motivation of behavior, and benefits of abreaction and catharsis in the treatment of neuroses. Freud found out that patients could recall past events without hypnosis through the use of "free association." Several of his ideas, like the theory of instinct, the concepts of repression and resistance, dream interpretation, concept of infantile sexuality, and stages of psychosexual development have influenced psychiatric thought until the present time. His new technique was called psychoanalysis. Adler, Abraham, Rank, Ferenzi,Jung and Bleuler became interested in this form of therapy and several branched out with their own theories when Dr. Freud proved to be relentless in his insistence that his concepts remain unchanged.

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[20]Coleman, p. 44.

[21]Ralph H. Major, The History of Medicine (Springfield, Il: Thomas, 1954), p. 164.

Abraham emphasized psychosexual development, while Ferenzi included more activity on the part of the therapist in analysis. Rank said that all anxiety was related to the anxiety of being born. Adler diverted from Freud and emphasized the importance of self-assertion as a personality drive, and proposed that people attempt to compensate for the feelings of inferiority by striving towards power, domination and superiority. He believed that aggression, not sex, was the most important motivational drive, and was credited with the term "inferiority complex."[22] Carl Jung taught that a person's unconscious had a personal unconscious, and a racial or collective unconscious, and maintained that every person has a need for religious experience, which led to his being called a mystic. He also had a unique interpretation technique for dream symbols, and developed new concepts of introversion and extroversion.

Dr. Blueler, after investigating Dementia Praecox for years, concluded it didn't always end in dementia, as was thought earlier, and opened up the whole treatment concept for that emotional condition. After applying psychoanalytic methods to the study and treatment of psychosis for years, he finally introduced the term "schizophrenia" to a group of psychotic disorders having common characteristics; he also divided the symptoms of schizophrenia into primary and secondary categories.

Karen Horney, Erich Fromm and Harry Stack Sullivan departed from the orthodox psychoanalytic theory, and began to emphasize the cultural and interpersonal aspects of behavior, and came to be called

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[22]Kleinmuntz, p. 255.

neo-Freudian. An Existential theory grew out of the philosophical climate in Europe through the writings of Kierkegaard, and theoretical material developed by Jaspers, Heidegger, Binswanger and Buber. Emphasis centered on the individual's experience in an event, not upon the events themselves.[23]

Though the medical model dominated psychopathology in the 19th century, there were important advances made:

1. Earlier affirmations about the place of demonology in mental illness was finally destroyed.

2. Appropriate methods of treatment of some mental disorders were developed.

3. A workable, though not complete, classification of mental illnesses was set up.

4. Mental illness was placed on a nearly equal basis with physical illness, at least in medical circles. Humane treatment of the emotionally disturbed was based on scientific findings of that time.

5. Research was begun in anatomy, physiology, biochemistry, and other medical sciences to find causes of brain pathology and organic causes for behavior.

There was a new breakthrough in genetics and neurophysiology, as efforts were being made to discover how brain defects and changes in internal chemistry could affect the disturbance in thought process and behavior.[24]

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[23]Eaton and Peterson, p. 516.

[24]Coleman, p. 24.

Tranquilizing drugs were introduced, which were admittedly not a cure, but did allow the person to stay in the community rather than being placed in the hospital. There were earlier discharges for mental hospital patients, and the need for restraints and locked wards diminished when the agitation in the patients was lessened through the drug therapy.

Contemporary progress in understanding and treatment of mental disorders is not, however, just from medical science. There is also a new recognition that psychosocial factors are involved in normal and abnormal behavior. In the early 20th century, most abnormal behavior research determined that organic pathology in the brain was at the root of all mental disorders. This view is now being challenged, but new evidence surfaces occasionally to support organic and biochemical causation.

Twentieth Century Developments

Physiologic elements of mental disorders were emphasized by some neuropathologists and neuroanatomists. Charcot's hypnosis concepts led to new concepts of investigation and treatment of mental disease. No new physical treatment methods were introduced until Manfred Sakel began using an insulin coma treatment for schizophrenia in 1933, and Dr. von Meduna of Budapest initiated the use of metrazol to induce convulsions in 1935. Electro-convulsive treatment was introduced by Doctors Cerletti and Bini. Psychosurgery was originated by Dr. Moniz in Portugal, and brought into the United States by Walter Freeman. Pharmacologic treatments included barbituates and bromides until they

were generally replaced by the newer sedatives and tranquilizing agents which developed after the introduction of chlorpromazine in 1954, and brought about a major change in the treatment of schizophrenia and other psychoses.[25]

The reader is reminded of the opening statement on page 3 that the history of schizophrenia is the history of behavior pathology itself. We have seen in this chapter that the condition now known as schizophrenia has existed for as long as history has been recorded, but the understanding of it has slowly and gradually developed as a part of the cognitive evolution of mental illness concepts, which seemed to spring up in various parts of the civilized world. It still remains among the most bewildering of psychotic disorders and is still not well understood. This is unfortunate for it is most disabling, affecting nearly one per cent of the population, and accounting for two thirds of the residents in mental hospitals.[26] An intensive look at the emotional condition known as schizophrenia will be taken in the next chapter,to gain further insight into the cause-effect syndrome that is so perplexing.

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[25]Eaton and Peterson, p. 512-515.

[26]Kleinmuntz, p. 260.

CHAPTER II

THEORIES OF SCHIZOPHRENIA

In the previous chapter, the fluctuating and painful ascent of society's understanding of mental illness was traced from the pit of demonology and witchcraft up to the concept that it has physiological and environmental origins. Mental illness applies to a wide variety of behavioral deviations, and the diagnostic manual of mental disorders of the American Psychiatric Association gives the classifications and diagnostic categories which in reality are more definable in theory than in practice:[1]

mental retardation	psychophysiological disorders
psychoses	transient situational disturbances
organic brain syndrome	special syndromes
neuroses	behavior disorders in child and adolescent
personality disorders	conditions without psychological disorders
non-specific conditions	

It is the intention of this dissertation to focus upon the psychosis known as schizophrenia. Dr. Carl Pfeiffer, however, refers to this condition as <u>schizophrenias</u> because there are seven elements making up the illness: dementia paralytica (brain syphillis), pellagra (niacin deficiency), porphyria (abnormal form of chemical blood pigment) homocysteinura, thyroid deficiency, amphetamine psychosis and Vitamin B-12-folic acid avitaminosis. There are also variations in the severity duration, and symptomology of these seven categories which creates

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[1]American Psychiatric Association, "Diagnostic Manual of Mental Disorders II," 1968.

considerable difficulty in a valid diagnosis of schizophrenia.[2] Terms such as simple, hebephrenic, paranoid and catatonic, are not always useful categories because, except for paranoids, the untreated patient may change from month to month from one to another of these categories. For example, some females experience schizophrenia at menstrual or pre-menstrual periods, while others have a post partum psychosis after the birth of a baby.

Although there are disagreements within the medical and psycho-therapeutical disciplines about the relevant merits and demerits of diagnostic labels, and particularly in schizophrenia, information about this mental disturbance will be needed to provide background for the subject and later treatment modes.

Schizophrenia is considered to be the major mental illness for several reasons: patients with a schizophrenic disorder make up 20-25 per cent of admissions to mental hospitals or psychiatric wards of medical hospitals. Fifty per cent of the resident mental hospital population is under the schizophrenic description, mainly because the treatment of the more chronic cases requires longer hospitalization. In terms of human suffering, lost productivity, and public expense for health care, schizophrenia is a major health problem in modern society. Schizophrenia has been observed in all parts of the world, and includes about one per cent of the general population in all cultures in which studies have been made.[3] There is an almost equal ratio of men and

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[2]The Professional Committee of the Schizophrenia Foundation of New Jersey, "The Schizophrenias-Yours and Mine" (Princeton, NJ: Pyramid Books, 1970), p. 23.

[3]Felix von Mendolssohn, M.D., This is Psychiatry (New York: Watts, 1964), p. 23.

women with this disturbance, and the peak age incidence is between twenty-five and thirty-five years of age.[4]

The Diagnostic Manual of the American Psychiatric Association gives the most competent description of schizophrenia:

> This large category includes a group of disorders manifested by characteristic disturbances of thinking, mood and behavior. Disturbances of thinking are marked by alterations of concept formation which may lead to misinterpretation of reality and sometimes to delusions and hallucinations, which frequently appear psychologically self-protective. Corollary mood changes include ambivalent, constricted and inappropriate emotional responsiveness and loss of empathy with others. Behavior may be withdrawn, regressive and bizarre.[5]

> The Schizophrenias, in which the mental status is attributable primarily to a thought disorder, are to be distinguished from the major affective illnesses which are dominated by a mood disorder. The Paranoid states are distinguished from schizophrenia by the narrowness of their distortions of reality and by the absence of other psychotic symptoms.[6]

Schizophrenia led both general diseases and mental diseases as the cause of hospitalization in 1962. Fifty-one per cent of the hospital census was in psychiatric wards. There were more people in hospitals for mental illness than for arthritis, cancer, heart disease, tuberculosis, and all other diseases combined. Ninety-eight per cent of all mental patients are in public hospitals, and only two per cent are in private hospitals.[7] It is often said that heart disease is the number one killer, but the nation's main cause of hospitalization is schizophrenia.

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[4]Kurt Salzinger, Schizophrenia: Behavorial Aspects (New York: Wiley, 1973), p. 212.

[5]The Professional Committee, p. 5-6.

[6]Ibid.

[7]See Appendix F for 1960 Diagnosis of Patients of the Psychiatric Wards in the United States, p. 141.

DESCRIPTIVE DATA

There are several major types of schizophrenia, distinguished by symptom clusters, which provide background for the layman or professional who is a part of a treatment process. Although attention is being given to these symptoms, it is important to remember that, though the person may be somewhat or severely disturbed, he is still a person with personal resources, both obvious and hidden, with which to deal with the condition of disturbance. Most schizophrenics are not raving maniacs or bizarre comics, as some Hollywood films suggest. The patient is not always 'out of it.' Only some of the patient's ideas are delusional, only some of the language used is unintelligible. Hallucinations occur only part of the time, and not necessarily every day or even every week.[8]

Derivation of Terms

Most of the valid information about schizophrenia has come in the last two centuries. The first cognitive understanding of this condition was evidently originated in 1674 with a British anatomist named Willis, and was expanded upon by the French psychiatrist, Morel (1809-1873). He pioneered in the social aspects of psychiatry,insisting on the frequent connection between undesirable environmental factors and mental disease. It was truly descriptive that the illness is, at its worst, a dementia, or insanity, which occurs mainly in young

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[8]Paul Mussen and Mark R. Rosenzweig, Psychology, An Introduction (Lexington, MA: Heath, 1973), p. 238.

people, as implied by the Latin adjective praecox translated as youthful in English. Kraeplin understood the condition to be a disease process that began in adolescence or early adulthood and had a deteriorating effect which culminated in a dementia, or a permanent impairment of the mental powers.

A Swiss psychiatrist, Bleuler, developed the term schizophrenia (1911) from two Greek words: schizen (to split) and phren (mind or personality). It differs from the earlier description which described the condition as an "insanity occurring in youth" in that it shows the nature of the disease to be a "splitting of the mind or personality."[9] Although Kraepelin had earlier described the disease and classified it into numerous types and subgroups, it remained for Bleuler, a contemporary of Kraepelin, to transform the understanding of the disease from a descriptive clinical curiosity to an understandable, dynamic clinical entity, and eventually to substitute the term schizophrenia for dementia praecox.

Bleuler defined schizophrenia as a chronic, malignant mental disease process with both primary and secondary symptoms, which usually began in the late teens and early twenties. He suggested it was chronic, because it continued for a long time like tuberculosis and other long-standing ailments, and was not generally acute. By labeling it as malignant, he meant that it was incurable, that no one ever recovers from it completely but, like the treatment for cirrhosis of the liver, the symptoms may be eliminated without touching the basic pathology.[10]

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[9]Robert R. Mezer, M.D., Dynamic Psychiatry in Simple Terms (New York: Springer, 1960), p. 61.

[10]Ibid., p. 63.

Primary Symptoms[11]

Bleuler and others sifted the primary symptoms into at least four underlying, chronic basics which make up the malignant process and become the pathology of the schizophrenic. These will be described as "splits" since it is a "splitting" disease.

1. Split of affect, mood, feelings or emotions. Normally, the affective disturbance usually takes the form of a flatness or affect, a lack of outward display of emotion. Inappropriate affect, or an apparent disassociation between affect and thought content (e.g. laughing when a tragedy in life is described or that of a member of the family) may be present. The inappropriateness of affect is often more apparent than real, more a matter of outward display than actual feeling. The person feels that people in the immediate environment, including the therapist, are hostile and threatening. Words and manner are used more to conceal than to reveal feeling.
2. Split of associations. Normally, links or associations hold our thoughts and thinking processes together. For the schizophrenic person, there is little sequence of relationship in thoughts; they become isolated units and are called dis-association. Almost any kind of an answer can be expected. One patient's response to a question went this way: Q. What do you think of a trial marriage? A. "I don't know. I don't

[11]Ibid., p. 63.

"believe in marriage, and a trial marriage is just as bad as any other marriage, and why should a trial be involved in marriage, especially when there's no judge."

3. Split of attention. This represents an inability to keep the mind focused on any one subject, and attention is directed to many different things at the same time, with no control to focus it on a single activity, even if the person wishes to do so. Thus, the schizophrenic patient is preoccupied with his attention somewhere else. This inability to concentrate is an early sign of schizophrenia. Another patient reported her feelings this way: "I can't concentrate. It's the diversion of attention that troubles me. I am picking up different conversations. It's like being a transmitter. The sounds are coming through to me, but I feel my mind can't cope with everything. It's difficult to concentrate on any one sound."
4. Split in the sense of reality. This one is perhaps the most important. Normally there is a barrier between the ego and the external world, which becomes the sense of reality and identifies people as individual personalities, separate from the world around them. The self is diffused, fragmented, and largely lost for the schizophrenic; he/she may experience various degrees of confusion about who he/she is, because the person melts into the outside world and becomes a entity in his/her own self. One such person said, "I am starting to feel pretty numb about everything because I am becoming an object and objects don't have feelings." Trying to force the patient

back into reality is likely to arouse negative and hostile reactions. Many persons will try to reestablish contact with reality in their own time and way. They tend to fade in and out of reality.

5. Delusions and hallucinations. Bleuler calls this "ideas of reference" in which the person puts him/her self in things or events that are happening in the outside world. If someone hits the table with a fist, the schizophrenic may feel like he/she is being hit. As sense of reality disappears, panic dreams appear; dreams of catastrophe, such as earthquakes, make it seem as if everything in the mind is disintegrating and slipping away. As the real world slips away, a substitute world takes its place, a world created by the individual, and made up of significant concerns, but quite incomprehensible to the normal individual. The person may invent words with wholly personal meaning and significance, but mean nothing to anyone else.

A warning is important to anyone trying to make an estimate of the schizophrenic's condition. Not all symptoms occur in a particular case. The symptom picture may differ markedly from one person to another. The symptom picture may also be influenced by an individual who is being labeled as schizophrenic and given the "sick" role. Progress may vary markedly with time. The person may be in good contact one day and show delusions and hallucinations the next day. It is entirely possible that an acute episode of schizophrenia may clear up rapidly or may progress to a more severe and chronic condition. This is another evidence to support the claim that schizophrenia is one

of the most serious of all psychotic disorders, as well as one of the most baffling.[12]

Secondary Symptoms[13]

In physical medicine, the body attempts to get along with a damaged organ even though some handicapping may be involved. In the psychological arena, the psyche of the person attempts to halt the disintegrating process in which reality is slipping away. There are efforts made to restore normalcy, which became defenses constructed to safeguard the person's selfhood. These defenses are entirely different from the above primary symptoms and are referred to as types of schizophrenia:

1. Catatonic type. This defense could be labeled as denial; the individual will try to deny that his sense of reality or his ego is disappearing or melting away, in one of two ways:
   a. Catatonic excitment or furor: Here the person, by over excitable frenzy, will try to push the world away from him. He/she may become maniacal, may run amok wildly, kick, scream, thresh, defecate, urinate,or find any other possible expression with which to kick the world away from him/her, blot it out, and deny anything is wrong. He/she may not stop to eat and may starve to death or die from exhaustion or from knocking his head against the wall.
   b. Catatonic withdrawal: In this condition, the schizophrenic is denying the real life situation by completely withdrawing

[12]James Coleman and William Broen, Jr., Abnormal Psychology and Modern Life (4th ed., Glenview, Il: Foresman, 1971), p. 273.

[13]Ibid., p. 273-283 and Mezer, p. 70.

from the world. There is absolute silence and isolation; a refusal to open the mouth for food, and no response to questions. The hands, feet, or whole body exhibit a waxy flexibility, and can be put in postures which will be maintained for such a long time that edema develops from remaining in that position. It is as if the individual loses contact with the sense of gravity, as well as the sense of reality; the person can do unusual things involving strength and daring such as moving extremely heavy weights because he is not handicapped by an awareness of reality which restricts the normal person. Both types of catatonic schizophrenia are very serious and possibly fatal.

2. Paranoid type. About one half of all schizophrenic first admissions to mental hospitals are of the paranoid type. Often there has been a history of suspiciousness or interpersonal difficulties. The individual is dominated by absurd and changeable delusions, such as feeling that relatives or associates are talking about him/her, trying to poison him/her or are influencing him/her by electrical devices. All this attention leads one to feel he/she must be an outstanding person, which develops into delusions of grandeur and may also create visual or auditory hallucinations in which Jesus or angels may be seen or voices from God or enemies may be heard.[14]

One of the functions of the ego is to make the unconscious stay unconscious, to keep the content of the unconscious from

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[14]Coleman, p. 275.

bothering the personality. When the ego begins to disintegrate, as in schizophrenia, when personality loses its hold on the external world of reality, the ability to keep the internal feelings and impulses unconscious or repressed, is also lost. When these thoughts surface, they are too terrifying for the person to handle within himself/herself, and he/she begins to project them onto the outside world, so he/she can be angry at a world which thinks him/her to be a homosexual, or some other kind of different person; this is a much easier escape than to face the fact that these feelings really exist within himself/herself. Such thoughts and feelings from the individual's unconscious are projected onto someone else, and directed back to himself/herself to make up delusions and hallucinations which are characteristic of this type of schizophrenia. A paranoid schizophrenic can be dangerous, as when he/she attacks someone he/she is sure is persecuting him/her. In general, there is less extreme withdrawal from the outside world than with most types of schizophrenia. Both Freud and contemporary investigators have pointed to the frequency of homosexual conflicts in the paranoid schizophrenic, though the meaning of this is not clear as yet.

3. Hebephrenic type. A more severe disintegration of the personality is shown in this type than the other types of schizophrenia. There is a history of oddness, preoccupation with religious and philosophical issues, a brooding over masturbation or anti-social behavior. This type person

gradually becomes emotionally indifferent and infantile in his reactions. The defense mechanism is to regress or go back. If one is losing ones world, one can go back to the time when that world was secure. Persons in this state often become silly and childish; they laugh and giggle. Hallucinations are the most vivid of all schizophrenic types, but childishness is the main characteristic of the hebephrenic.

4. Simple type: This condition begins slowly and fairly early in life, often during adolescence. Lack of interest in school, withdrawal from social relationships, little concern for family or friends are characteristics of the simple type. This kind of person has no ambition or goals in life and portrays a sort of hobo personality that floats through society from one place to another with no purpose in existence. There seems to be no reason for living, so living goes in an "ivory tower." A small percentage of these persons become hospitalized because they are usually able to get by in the outside world through the help of relatives, or are able to do simple manual labor to support themselves. Some superficial contact with reality is maintained.

Schizophrenia is in a constant state of flux, and persons will show different characteristics on different days. Paranoid type is the most common, catatonic is the next most common, and hebephrenic is least often seen clinically. The simple type is least often diagnosed and least often seen in hospitals and causes little or no trouble in society. Paranoid schizophrenics do give trouble, often calling police

with a long tale of persecutory woes. Society finds it difficult to tolerate paranoid or hebephrenic behavior because of its often disturbing or dangerous overtones.[15]

In describing the characteristics of schizophrenia, there have been some efforts to simplify the diagnosis. Since symptoms are not clearcut, there is poor reliability, and diagnosis is not satisfactorily sound. The interviewer often influences the behavior of the person, and is influenced by the person's behavior that is of particular interest, as it concerns the interviewer's theory, practice and personal prejudice. In order to reduce the variance of a too heterogeneous assortment of patients, and to be able to evaluate individuals in somewhat the same relevant dimensions, two categories are being used to describe the condition in many places: process schizophrenia and reactive schizophrenia.[16]

General characteristics of process schizophrenia usually include a long sickness, lack of interest in environment, excessive day-dreaming, blunted affect, and mildly inappropriate responses. The prognosis is usually poor, because treatment did not begin early enough. Allowances must be made, however, for differences in cultural backgrounds before establishing a definite diagnosis.

Reactive schizophrenia occurs within people who are seen as adequate; it has a sudden, acute onset with intense emotional turmoil, a nightmarish sense of confusion, and can be traced to definite triggering events. Here, prognosis is good because the symptoms often begin to clear in a few weeks.

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[15]Mezer, p. 70.

[16]Salzinger, p. 18.

Earlier conclusions determined that process disorders were of genetic and constitutional origin, and that the reactive disorders were of psychogenic origin; however, more recent studies seem to indicate that they are two endpoints on a scale of greater (process) to lesser (reactive) psychopathology.[17]

BIOLOGICAL FACTORS

Despite the long history of schizophrenia, its causes still remain undiscovered. There is conjecture whether the origins are, as had been presumed until this century, biological, or whether there is a combination of biological and other factors interacting complexly. Psychiatrists are forced to state that they simply do not know; it takes courage to admit that the cause of such an important and frequent mental illness is unknown. So two chronic ailments in modern society, schizophrenia and the common cold, remain in the "for future enlightenment" category. It will be important to this study to consider, briefly some postulates about the origins of the schizophrenic reaction.

Genetic

Paul E. Meehl, a researcher in the genetic field, was asked how he would choose a likely candidate from the population, without having any knowledge of behavioral traits, who would have predisposition for schizophrenia. His answer: "There is only one thing you could write down that would give you better than even chance of winning -- namely, 'find an individual who has a schizophrenic identical twin'...

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[17]Kleinmuntz, p. 267.

Schizophrenia, while its content is learned,is fundamentally a neurological disease of genetical origin."[18] This statement is typical of those who support the "twins theory" that if one identical twin develops schizophrenia, the other has only a 15 per cent chance of escaping psychosis, and if the twins are separated early in life, chances are slightly increased. This condition does not exist with fraternal twins as significantly,suggesting that genetic factors play an important role in the development of the disorder. Rosenthal, who supports much of Meehl's conclusions, leans toward a heredity-environment complex, in which there is an inherited psychopathological tendency for schizophrenia, but the manifestation of it depends greatly on the kinds of stresses encountered by the person, and his predisposition; these stresses could be trauma, disease, alcohol, drugs, childbirth, or exhaustion. He feels that recovery or remission occurs when physiological aspects or stresses are reduced.[19]

It is the writers opinion that researchers in the genetic field would generally support Rosenthal,in that heredity may play an important part in causing a disorder,since it may be a necessary condition for it to occur, but heredity alone is not adequate or sufficient to trigger schizophrenia. This suggests that there is an interaction between a number of agents to produce this condition.

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[18]Paul E. Meehl, "Schizotaxia," American Psychologist, VII, (1962), 827-838.

[19]Rosenthal, Genetics of Psychopathology (New York: McGraw-Hill, 1971), p. 214-227.

Neurophysiological

More recent advances in brain research have added new possibilities to the proposition that excitatory and inhibitory processes predispose some people to behavioral disorganization in stressful situations. This is a relatively new research frontier,and no general conclusions can be drawn prematurely;concurrence from further studies may open up new areas for understanding and treating schizophrenic disorders.[20]

Biochemical

Behavioral scientists have consistently tried to find biochemical substances in abnormal persons, because therapy could then be aimed at removing or destroying these harmful substances. Discovery that hallucination-producing drugs, such as mescaline and lysergic acid, produce model psychoses in normal people suggested that schizophrenics might be producing a psychotomimetic drug in the blood system.[21] A similar study found that schizophrenic patients produce an abnormal blood substance called TARAXEIN (from the Greek word meaning "to be disoriented or disorganized"), which is a protein that combines with other bodily substances to become toxic to the central nervous system; EEG brain wave recordings resembled those of psychotic patients, produced symptoms of catatonia-like behavior, suspiciousness, autism, and grandiosity. Although these studies are extremely important in the search for origins of schizophrenia, the findings have not been conclusive, and several methodological problems still need to be overcome; it is still not known how the substances are produced, how they

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[20]Coleman, p. 284-285.

[21]Salzinger, p. 126-127.

do their damage, why toxic quantities of these substances are found only in schizophrenia and, most importantly, whether they reside in pre-schizophrenics and could be detected for early treatment.[22]

Prolonged Sleep Loss

Andrew White described, in 1896, the "tortura insomniae" treatment used for those accused of witchcraft. The afflicted ones would be denied sleeping or resting, night after night and day after day. Temporary delusion became chronic insanity, mild cases became violent, torture and death ensued.[23] Investigators have also suggested a relationship between schizophrenic reactions and sleep loss. Some research findings have cast interesting light upon this are: extreme sleep deprivations have produced irritability, visual hallucinations, disassociative states, and paranoid thinking; sleep-deprived subjects are more susceptible to effects of lysergic acid; progressive mental deterioration occurs after seventy two hours of sleep loss. One implication is that a person having sleep loss as a result of some emotional crisis, might be less able to adjust to a situation he/she might normally handle quite well. There has been interest in showing the relationship between hallucinations and the dream states that occur during sleep; a decreased REM (rapid eye movement) sleep seems to be associated with more acute and active phases of schizophrenia.[24]

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[22]Kleinmetz, p. 272.

[23]Andrew White, History of Warfare of Science and Theology in Christendom, (New York: Appleton, 1896), II, 119.

[24]Kleinmentz, p. 273.

In making an assessment of the biological effect on the schizophrenic person,much caution is required in evaluating the findings of researchers; the biological agents may play an important role in terms of schizophrenic origins, but whether they are primary causes of schizophrenia, or only secondary effects of it, is difficult to determine at this time.[25] A concluding statement by M. K. Horwitt is descriptive of our dilemma:

> Year after year, papers appear which purport to distinguish between the state of schizophrenia and that of normalcy. The sum total of the differences reported would make the schizophrenic patient a sorry physical specimen indeed; his liver, brain, kidney and circulatory functions are impaired; he is deficient in practically every vitamin; his hormones are out of balance, and his enzymes are askew. Fortunately many of these claims of metabolic abnormality are forgotten in time... but it seems that each new generation .... has to be indoctrinated or disillusioned without benefit of the experiences of its predecessors.[26]

PSYCHOSOCIAL FACTORS

R. D. Laing, a psychiatrist from the British Isles, maintains that "the experience and behavior that is called schizophrenic is a 'special strategy that a person invents in order to live in an unlivable situation.' He calls this the person's position of checkmate, a state of affairs that may not be perceived as such by someone in it. And he suggests that the social system, not persons within it, must be the object of study if one is to understand these persons."[27]

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[25] Coleman, p. 289.

[26] M. K. Horwitt, "Facts and Artifacts in the Biology of Schizophrenia," Science, CXXIV: 3 (1956), 429-430.

[27] R. D. Laing, Politics of Experience (New York: Ballantine Books, 1967), p. 115.

Kurt Salzinger states that we are directed to a potential patient through social behavior, that is, by the way he/she interacts with other people.[28] Accordingly, some of the experimental elements in the schizophrenic's environment which influences his behavior will now be examined.

Parent-Child Relationship

A neo-Freudian, Harry Stack Sullivan, introduced the idea of interpersonal psychiatry and, within this framework held that schizophrenia was an indirect result of poor interpersonal relations between the child and his parents. Sullivan felt that a child is intuitive in picking up anxiety from the mother through the process of empathy, and avoided people or situations which may evoke anxiety; there may be withdrawal from contact with people, and he/she may resort to personal interpretations of reality.[29] During the child's early life formation, Sullivan suggested, it is important that he/she learn to test reality and think logically, to develop some expectations about the effect of his behavior in interpersonal situations, and to begin to learn how to communicate and interpret verbally and nonverbally with others and understand the general idea of cause and effect, which is essential to logical thinking.

Jay Haley says that there is an art to being schizophrenic, that one must begin by being born into the right family and then all

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[28]Salzinger, p. 128.

[29]Harry Stack Sulliven, Clinical Studies in Psychiatry (New York: Norton, 1953), p. 194-201.

else may follow.[30] A system of relationships is constructed within the family of a schizophrenic in which the parents and siblings unconsciously, but not always so subtly, treats one family member in such a way as to make it necessary for that person to build pathological defenses to cope with emotional deprivations and loneliness experienced between parents and the other family members. Relationship between mother and father is usually one of non-intimacy and frustration and this condition leads to emotional transference to a child of opposite sex from the parent.

Recognizing that a dysfunctional marital relationship is contributing to the development of a schizophrenic person and is generated by some specific behavioristic attitudes in each spouse, it may be helpful to describe some interpersonal parent-parent and parent-child relationships.

The mother of a schizophrenic male is typically rejecting, dominating, cold over protective and insensitive to the feelings and needs of others. She may verbally accept, but basically reject, the child, yet she depends on him, rather than the father,for her emotional satisfaction and feelings of completeness as a woman. She tends to dominate and smother and keep him dependent on her. There are usually strong, rigid, moralistic attitudes toward sex. She may be overly seductive toward the son. This fosters immaturity and anxiety in the child, depriving him of a clear cut sense of identity, and causing him to have inadequate feelings, and giving him a sense of helplessness.[31]

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[30]Jay Haley, "The Art of Being Schizophrenic" See Appendix A, p. 125.

[31]Coleman, p. 291

The father of a schizophrenic female is generally inadequate, indifferent, passive, with a detached and humorless attitude toward life. He probably rivals her mother in his insensitivity to other's feelings and needs. He appears rejecting toward the son and seductive toward his daughter. He often shows contempt and criticism for the wife, showing that the daughter is more important to him, thus forcing the wife into competition with the daughter, while he devaluates her as a model for the daughter's development as a woman. The daughter may despise herself for any resemblance she may have to the mother, and will move into adulthood having some incestuous attachment to her father that creates inner conflict, and proves terrifying.[32]

Communication Patterns

Gregory Bateson has developed the "double-bind" theory of the origins of schizophrenia which predicates a communication problem between child and parents, and where impossible demands are placed by parents on people in infancy and early childhood. In the severely schizophrenic home, anything the child does to meet the demands of one parent automatically displeases the other; but the child may not admit that this exists, and is caught up in an impossible task -- inherently an unsuccessful one -- of keeping his level of anxiety decreased by placating and sublimating his own selfhood. The son is dependent on the mother for love and affection, yet is punished for both showing outward signs of love toward her, and for not displaying such affection. He is

[32]Ibid, p. 292.

"damned if he does, and damned if he doesn't." The mother may deny such a situation exists, and the father may be too passive to intervene, so the child cannot win, becomes anxious, and is unable to organize his thinking.[33]

Dysfunction Between Parents

When there is a marital tension in the home, the schizophrenic child finds it difficult to handle this stress. The child is denied a close relationship with parent(s) which he/she needs for later "modeling" purposes. Two studies in 1950 and 1957 respectively, showed open discord between parents existed in 87 per cent of schizophrenic persons compared with 13 per cent in normal subjects, and that in fourteen families of schizophrenic offspring, there was not one single family reasonably well-integrated. These children tend to break down in young adulthood, when a sense of identification is essential for an independent adult role.[34] Other research has shown, however, that childhood and adolescent experiences of schizophrenia do not differ noticeably from those who are not so afflicted.[35] It has been the writer's personal experience that there is at least a small correlation between stress and acceptance at home, and the future stability of the potential schizophrenic personality. Jay Haley said that members of schizophrenic families are not consistent when they interact with each other, by what they say to each other, and then they disqualify each

[33]Gregory Betteson, "Toward a Theory of Schizophrenia," Behavorial Science, I (1956), 221-239.

[34]Coleman, p. 292.

[35]Kleinmuntz, p. 277.

other's statements. The child finds his/her own feelings and acts are stripped of their real meaning and he/she becomes totally mystified and alienated and one's personhood becomes denied.

Family Patterns

A rather interesting study that seems to bear itself out in experience for this writer was done by Rogler and Hollingshead[36] in which their interviews with forty families of hospitalized schizophrenics pointed out that the schizophrenic husband's spouse is able to maintain the family stability by various means, and the husband becomes dependent on the spouse, and the extended family. In the case of a schizophrenic wife, the family is thrown into discord, confusion and chaos when the husband is not able to cope with his sick wife's pathology; their relationship deteriorates when he increasingly absents himself from the home, and defiance toward him increases as she feels rejected and isolated from relationship.

Another interesting aspect of family patterns is shown by two current writers in the field. R. D. Laing, in analyzing the web of influence in the psychotic's life, believes "that as many as three generations can be involved, so that the patient's grandparents and great-grandparents, though long since dead, may figure as major actors in the ferocious drama of the psychotic household."[37] James Framo also subscribes to this multi generational complex of factors influencing the emotional fabric of an individual.[38]

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[36]Kleinmuntz, p. 277.

[37]Laing, p. 48.

[38]James Framo, Family Interaction (New York: Springer, 1972), p. 101-173.

SOCIOCULTURAL FACTORS

Social Class and Therapeutic Treatment

Facts show that schizophrenic disorders are predominantly more common in lower socioeconomic groups than in upper strata of society. It is too simple to say that poverty is the main cause yet there is greater incidence among the poor than among the rich according to some investigator's studies. There are cogent reasons: crowded living conditions violate a person's need for space; poverty makes it more difficult for mother to give adequate care to children; the father influence in homes of the poor is often minimal or weak; slum areas have poorer schools and limited recreational facilities; stress experienced during adolescence and early adult life, along with the frustration of fundamental needs by social and economic factors,creates a lack of ambition and the regressive process of schizophrenia begins.[39]

Research done by Hollingshead and Redlich[40] have shown, however, that poor persons do not receive the same kind of diagnostic and treatment considerations as those who are middle class and above, which may account for the greater incidence of psychosis among the poor. For purposes of the research five class levels were developed as follows:

Class I: Families with considerable wealth; head of family is highly educated and is a major professional person or important executive.

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[39]H. B. Murphy, Transmission of Schizophrenia (Elmsford, NY: Pergamon Press, 1968), p. 137-152.

[40]A. B. Hollingshead and F. C. Redlich, Social Class and Mental Illness, (New York: Wiley, 1958), p. 220-249.

Class II: Heads of families are college graduates and are lesser professional or second-line business executives.

Class III: Family head is high school graduate with perhaps some further training in college or in a business or trade school. Likely to be a shopkeeper, salesman, white-collar employee or skilled factory worker.

Class IV: Usually the family head has not finished high school, is likely to be employed as a semi skilled factory worker.

Class V: Family head normally has no education beyond elementary level and works as an unskilled factory hand or laborer.

Several conclusions from the study may have a profound impact upon the future of therapeutic treatment for mentally ill among the poor.

1. Clinical judgments appear to be biased with regard to Classes IV and V. Studies show that the diagnostician, given the same symptomatologies, will label the Class I - III person neurotic butthe Class IV-V patient will more often be diagnosed as psychotic. The content of mental hygiene is definitely middle-class in that the practitioner is himself usually saturated in Class I - II culture and automatically assumes that the lower classes cannot totally assimilate the ways of thinking and behaving that alone can insure the prevention and cure of maladjustments.

2. As one moves down the class ladder, the likelihood for schizophrenics to have continuous treatment increases while moving up the ladder there is increased likelihood of periods of remission and re-entry into treatment. Once one enters treatment the Class V schizophrenic is likely to be kept under psychiatric care. While the lower class neurotic is dismissed from treatment more quickly with brief therapy than comparable upper class patients, the lower class

psychotic is rarely perceived as "ready" to leave treatment and becomes chronic in diagnosis.

3. A survey of treatment expenditures in clinics show that Class I patients receive the most psychiatric therapy and Class V receive the least since the latter group invariably is under custodial care only with only occasional professional one-to-one care.

In a further study Imber, Nash and Stone studied a situation in which therapists were not allowed to select their patients and both therapists and patients were under administrative pressure to remain in psychotherapeutic contact. They found that lower class patients remained in treatment for significantly shorter periods than the middle class individuals. In addition, lower class patients were less likely to return for treatment after initial screening. When patients are not assigned randomly but are selected on the basis of suitability for psychotherapy, this difference disappears. In 147 patients whose therapy had been terminated at the time of data analysis no significant social class differentials are found in total number of interviews, average frequency of interviews or judged response to therapy.[41]

Not all aspects of schizophrenia are negative. Many borderline schizophrenics or "ambulatory" schizophrenics never enter a clinic or mental hospital because they have been able to adapt to the life stresses and avoid a severe psychotic break.

There have also been continuing observations concerning the productivity of some schizophrenics. It seems to depend upon the

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[41]S. D. Imber, E. H. Nash, Jr., and A. R. Stone, "Social Class and Duration of Psychotherapy," Journal of Clinical Psychology, XI (July 1955), 281-284.

individual personality and the profession which may be willing and able to tolerate certain kinds of behavior. Over the centuries, practitioners have commented on the brilliance of some persons who have had the schizophrenic symptoms (confusion, great degree of disperception, depression, or hallucinations), though this is not so of the large percentage of schizophrenics.[42] In an experiment in England at a child guidance center, Dr. Joan Itzherbert found that immediately preceding a psychotic episode, the child's I.Q. was increased immeasurably: during the crisis it was not measurable, and after the recovery the I.Q. dropped to about twenty points below the pre psychotic level. Modern biochemical research suggests that certain chemical groups of methyl are added to the brain amines before the schizophrenic illness, which results in a drug-like stimulation of the brain.[43]

Such prominent persons as MarilynMonroe, William Blake, Isaac Newton, Vincent Von Gogh and Judy Garland have been diagnosed unofficially as having schizophrenic tendencies, testifying to the ways in which they are able to function successfully in society, though perhaps not so successfully in their personal lives.

DIAGNOSTIC DILEMMA

There are increasing numbers of psychiatrists and other mental health practitioners who are questioning the whole concept of mental health diagnosis as a useful and fair practice. Jay Haley, a communications analyst, bemoans the sad state of psychiatric diagnosing, particularly in the area of schizophrenia. At one time a person was

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[42]The Professional Committee, p. 31-32. [43]Ibid.

either schizophrenic, or he was not, but today the label can be applied to most anyone, he says, and diagnostic guidelines are being altered which could include most anyone. He pleads for a clean and pure diagnosis in the European, and more particularly, the German tradition.[44] Coleman adds, that to label the schizophrenic, and put the sick role on him, will not only influence the individual's concept of himself, but also will affect his subsequent behavior.[45] R. D. Laing, a present-day maverick psychiatrist, tells about the myth of mental illness, and frankly states that:

> "we do not accept schizophrenia as being a biological, neurophysiological, psychological fact but regard it as a palpable error in the present state of the evidence to take it to be fact; nor do we assume its existence nor do we adopt it as a hypothesis. We propose no model for it."[46]

Laing and a colleague, Thomas Szasz, base much of their work on a conviction that there is, in fact, no such clinical entity as mental illness. They are not denying the possibility of mental illness, even schizophrenia, but they do reject its relevance as a label or a therapeutic tool. Their contention is that the psychotic person, so labeled, suggests an image, such as "felon" does in many minds, and a certain kind of sociological and clinical process is put in motion once that kind of diagnosis is made. Their position is that the behavior of the mentally ill makes sense from the patient's point of view, but the observers (family, clinicians, etc.) have not comprehended the position

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[44]Haley, See Appendix A, p. 125.

[45]Coleman, p. 305.

[46]R. D. Laing and A. Esterson, Sanity, Madness and the Family (2nd ed. New York: Basic Books, 1971), p. 12.

from which the individual acts and speaks. This confounds the observers, who then present reactive behavior that is often as bizarre as the labeled one. If the pressure on the patient can be lessened, much of his grotesque behavior vanishes.[47]

Edgar Z. Friedenberg is a critic of Laing who takes issue with this concept, and indicates that Laing cannot see that evil and cruelty in human personality is every bit as much a reality as is love and growth: evil, if it is a response to earlier abuse, is not a congenital condition, but is natural and probably inevitable. He says we all depend on this to make us what we are, and should not use this as a reason to deny that the results of evil and cruelty bring mental illness that must be classified in some way, difficult as that may be to accept.[48]

Thomas D. Szasz, a professor of psychiatry at the State University of New York, in Syracuse, is a caustic critic of psychiatric abuses, and is deeply concerned about the Mental Health Movement's threat to individual rights. He shows in his book[49] that the belief in mental illness, and the social actions to which it leads have the same moral implications and political consequences as had the belief in witchcraft, and the social actions to which it led. Those actions and consequences were the victimization of accused witches by means of imprisonment, torture and death. Today's practices involve persecution in the form of incarceration in mental hospitals, often for life;

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[47]Laing, p. 13-14.

[48]Edgar Z. Friedenberg, "R. D. Laing" (New York: Viking Press, 1973), p. 24.

[49]Thomas S. Szasz, M.D., The Manufacture of Madness (New York: Harper & Row, 1970).

forced therapy, including drugs; shock; surgery and deprivation of legal rights. Society isolates and stigmatizes the "heretic" or "deviate" for its own protection and, so it believes and claims, for the victim's own good. He documents the following parallel between the identifying, authenticating, and punishing of witches, to modern psychiatric practices: Witchfinders of old found a witch's mark on the body of the accused, such as a skin lesion, birthmark, scar, or mole, which was supposed to have been the brand-mark of the devil, and constituted the pact between that person and Satan. These "diagnostic signs" made it easy to diagnose anyone as a witch, but beyond this, a person could be branded by the devil with an invisible mark, which was bloodless and painless, and could be found only by pricking. If there was no blood or pain, the person was a witch. This spawned the profession of witch-finder, oftentimes being the physician, who was entrusted to find the witch's marks. This precipitated the head-finder's ritual. Hardly anyone was without some marks upon their bodies, as moles or stains. Thomas Ady recognized that many confessions of the witches were obtained by fraud or invented by the inquisitors. The direct line of progression can be traced from the witch's marks to the signs which schizophrenics are made to reveal, through projective psychological testing. Each of these diagnostic findings is used to incriminate the subject as witch, hysteric, schizophrenic and then used to punish him by means of theological, medical or psychiatric sanctions.

The fundamental similarity between the methods of witch-finders and psychopathologists, is that each perpetrates a cruel hoax on his

victim. Each plays the same "Heads I win, tails you lose." Szasz says that in more than twenty years of psychiatric work, he never had a clinical psychologist report on the basis of a projection, that a subject was a normal, mentally healthy person; while some "witches" survived their inquisition, no "mad-persons" survives the psychological testing. There is no behavior or person that modern mental diagnostician cannot easily diagnose as abnormal or ill.

The economic aspects of witchfinding are interesting, then and now. In earlier days, the witch-finder was paid by the community on a per-capita basis. Today's mental practitioners have high economic stakes in making sure that the incidence rate remains high and the myth of mental illness be perpetuated.[50]

These viewpoints represent only the surface expression of many mental health professions, who recognize the revolutionary transition that has been occuring this last decade in the psychotherapeutic field.

Diagnosis in mental illness today is caught in the clutches of a theory, method and nomenclature of a century gone by, and which does not fit today's life-style. In recent years, there has been a shift in psychiatry and psychology, from an emphasis on the processes existing within an individual, to an emphasis upon his behavioral relationships with other people. Jay Haley says "it is only when the focus is upon behavior existant within a relationship that psychotherapy becomes describable because by definition, psychotherapy is a procedure which

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[50]Ibid., p. 28-39.

occurs in a relationship."[51] Yet there is, inevitably, a lag in both terminology and concepts, and most psychotherapeutic language today is aimed at describing the psyche of the individual person. The framework and concepts for a new language are just now taking shape around certain key individuals who are pointing the way to the future.[52]

Harry Stack Sullivan took the first step when he tried to describe interpersonal relationships with concepts and theories developed for individual description.[53] Others, such as Timothy Leary, have continued in this attempt,[54] and it appears now that human relationships will be best described in terms of interpersonal behavior rather than intra psychic processes. Going from the individualistic to the two-or-more system means that most previous terminology will need to be phased out gradually to allow new nomenclature to be used. This will require openness on the part of mental health professionals and laymen alike.

SUMMARY AND CONCLUSIONS

This chapter has shown that an inherited biological component, occuring within the central nervous system, may be a necessary condition for schizophrenia, but this condition alone, without the presence of environmental stresses (physical or psychological) is not a sufficient

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[51] Hay Haley, Strategies of Psychotherapy (New York: Grune and Stratton, 1972), p. 3.

[52] Ibid.

[53] Harry Stack Sullivan, "Conceptions of Modern Psychiatry," William Alanson White Psychiatric Foundation, 1947, p. 91.

[54] Timothy Leary, Interpersonal Diagnosis of Personality (New York: Ronald Press, 1957), p. 4.

cause for the disorder. Certain biochemical substances may be responsible for the onset of schizophrenia, but this would probably be genetically incurred, inasmuch as a biochemical substance could not be constantly produced by the body to cause schizophrenia except by some physical trauma. There is evidence to indicate that schizophrenia is learned within the social context. It appears that there is no one clear clinical entity or causal sequence in schizophrenia, but there may be several maladaptive reactions resulting from an interaction of factors, as indicated in L. Bellak's research, showing that 80 per cent of 1,000 schizophrenic cases had various mixtures of organic and psychological factors involved in the pathology.[55]

Finally, substantial arguments were presented to indicate the evolution and revolution that is transpiring around the diagnostic evaluation and labeling of all types of mental patients. At the heart of the dilemma is the fact that psychotherapy is changing gradually from an intrapsychic approach to a therapy centered around behavioral relationships between two people or within a family; also there is good reason to question whether disease labels are valid in the mental health area.

Vocabulary has not caught up with the existential demands; consequently many mental health practitioners are dealing with the interpersonal behavior and,by default, are still cloaking this new concept in the nomenclature of the intrapsychic 19th century language; psychoanalysts, however still focus on intra-psychic material. As

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[55]L. Bellak, "Schizophrenia" (New York: Logos Press, 1958), p. 45.

usual, those who brave the new frontier of this movement can expect opposition and criticism.

Thus far this study has looked at the historical understanding of mental health, and more specifically, the schizophrenias. Since one of the new looks is psychotherapy is built around interpersonal relationships, the next chapter will deal with a theological framework as a viable support system for the interpersonal therapeutic relationship between counselor and counselee and between counselee and his world of human contacts.

CHAPTER III

THEOLOGICAL IMPLICATIONS IN THE TREATMENT OF THE MENTALLY ILL

Research by R. D. Laing

R. D. Laing is representative, in this writer's opinion, of the evolution occuring in the etiological and therapeutic concepts of mental illness, although he is considered to be a "young Turk" among the medical professionals; he was advised to give up his medical license by some of his peers in the profession, who saw him using the authority of a physician to advocate a nonmedical model of diagnosis and treatment for mental illness.[1] He has been cast in the role of a psychiatrist-prophet by many, as one of several who might lead this generation out of the mental health conceptual maze; his reputation for work done with psychotics, and schizophrenics, in particular, helped to bring him this status.

Laing's conceptual journey is helpful in the understanding of the main thesis of this chapter dealing with the theological and religious implications of the needs and feelings of schizophrenics, in family and therapeutic relationships. In his first book, The Divided Self, Laing makes no specific reference to the existence of the spiritual in a psychotic's life, or to any other world of Being except as seen in the natural or social sciences. There was no indication

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[1]Abram Hoffer, "Correspondence" Psychedelic Review, No. 7,(1969), P. 127-128.

that anything of importance was beyond the social interaction between persons. The existential insecurity said to be at the center of mental illness was just the demonstration of a personal uncertainty which the individual felt about himself and the natural world. "Being in the world means social interaction between persons and Kierkegaard's 'Sickness unto Death' is not the loneliness of the sould before God but the despair of the psychotic."[2]

In the decade between 1957 and 1967, however, Laing experienced conceptual change regarding the spiritual and mystical elements in the existence of the mentally ill, no doubt the result of his experience in Kingsley Hall in London, a family community for schizophrenics, which he founded in 1965. In this setting, he worked on the concept that schizophrenia was "not a psychiatric disability but one stage in a natural psychic healing process containing the possibility of entry into a hypersanity."[3]

It was his belief that psychiatric medicine had -

> "driven its patients insane with its murderous chemistry, surgery, and regimentation."[4] The schizophrenic would be helped more by a "sympathetic 'initiation ceremonial' through which the person would be guided with full social sanction and encouragement into inner space and time, by people who have been there and back again; schizophrenic experience was, at any rate in some patients, no more than the first step in a two way voyage which led back again into a new ego and an 'existential rebirth'."[4]

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[2]Peter Sedgwick, R. D. Laing and Antipsychiatry (New York: Perennial Library, 1971), p. 6-7.

[3]Ibid, p. 32.

[4]Ibid, p. 33.

Laing wrote in 1967 that:

> "Orientation means to know where the orient is. For inner space, to know the east, the origin or source of our experience. There is everything to suggest that man experienced God ... It seems likely that far more people in our time neither experience the Presence of God, nor the Presence of His absence, but the absence of His Presence. With the greatest precautions, we may trust in a source that is much deeper than our egos -- if we can trust ourselves to have found it, or rather, to have been found by it. It is obvious that it is hidden, but what it is and where it is, is not obvious."[5]

In another writing, he draws an explicit analogy between the role of psychoanalyst and that of the religious practitioner:

> "I believe that if we can begin to understand sanity and madness in existential social terms, we, as priests and physicians, will be enabled to see more clearly the extent to which we confront common problems ... among physicians and priests there should be some who are guided, who can eject the person from this world and induct him to the other."[6]

He asserts that the schizophrenic patient has taken on a lonely adventure back to the Source or Oneness, and after experiencing that rebirth, makes the journey back to 20th century life again. He aligns himself somewhat with Jung in his emphasis on religious archetypes which are necessary to the integrity of the personality. But neither Jung or Freud, or any of their followers, would state that psychosis is a higher form of sanity, as did Laing. "Schizophrenia is breakdown, sheer affliction, for virtually all psychiatric schools; only for Laing does it mean also breakthrough and blessing."[7]

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[5]R. D.Laing, Politics of Experience (New York: Ballentine Books, 1967), p. 136.

[6]R. D. Laing, "Transcendental Experience in Relation to Religion and Psychosis," Psychedelic Review (1965), p. 114.

[7]Sedgwick, p. 39.

In a BBC radio broadcast in 1970, he said:

> "Yes, I quite agree that all the propositions of the Apostle's Creed are false or meaningless. Yes, the justification of faith in terms of miracles, or the appeal to Scripture, or through any of the traditional theological arguments for God, is absolutely fraudulent. But I am a religious man, I can't justify it logically at all, I just find it irresistible. I have been brought up to take religious propositions seriously. Those of us who cannot help outselves are compelled to continue the impossibly absurd project of keeping these forms of revelation alive."[8]

Laing does not seem to subscribe to much, if any, of the theological strategy of the institutional church, even though he was, himself, raised as a Presbyterian in the state church of Scotland. His remarks on the radio broadcast described above, appear to affirm his basic belief in the regenerative potentials of the Presence of God in the inner space of one's being. The writer believes he is asserting that there is more to life than what can be seen, heard, touched and felt, either physically or sensually. This becomes a spiritual, non physical relationship in the divine-human encounter, that builds an awareness in an individual that he/she is not alone, alienated or unacceptable.

Mary Barnes, a resident at Kingsley Hall for several years, as a patient and later a co-worker with Laing and Joseph Berke, tells of her own personal and painful journey to establish the divine-human relationship.

> "It's the inner state that matters ... How many ... reach through to integration, wholeness, sanctity? It's what we are all made for, given time in this life to achieve. Yet, never for one moment, do we 'make it' of ourselves. God, through other people, reaches out to us and draws us on. It's a question of suffering,

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[8] The Listener (April 23, 1970), 536-537.

"but the suffering for many of us means madness before sanity -- sanctity -- wholeness. We go from false self, to madness, to sanity ... A very twisted up person cannot get free without being allowed extremes of behavior. Regression is a safety valve; playing, bashing about, screaming, sucking, laying naked, wetting the bed, are all ways of getting the anger into the body, without hurting the body ... they have to be allowed, encouraged, to be as 'baby' as they feel and emotionally re-grown until they can participate in what might be termed a more 'spiritual' level of development.

Just as one doesn't give a 1-1/2 year old baby tranquilizers, or kneel him down to meditate, so much one not have expectations of a person in madness utterly beyond his state ... The person must be seen and understood as the baby he is -- and allowed to live that way, through it. He is dying to be loved, to be wanted, to be accepted. He has within himself to emotionally accept, to feel, all the anger, the anguish of the past, to go through periods of deadness when nothing at all can be felt, to be green with enry and hating with jealousy. Still, he must be loved, totally, for what he is, as a baby needs love.

How to let go, lay down, break, be held, be beyond words, float is a matter of trust. It's trusting God, through another person and no matter if so called 'mistakes' are made, God doesn't 'drop' us ... Madness is Purification. To go through it needs a guide, in terms of our world today, a psychotherapist. It has to be gone <u>through</u>, not around, and only someone else can keep us there.

The feeling of shame, guilt, that brings us to a dead stillness, makes all giving and receiving of love impossible, is a barrier to all creativity, causes us to feel as ghosts and bury our souls and bodies in 'living death' and is a <u>very</u> great sickness. When very twisted-up this way so the feelings and emotions are not true, the impulse of being is to break down. To resist is 'screaming agony' or 'living death.'

To be helped, to make the break, to go <u>through</u> madness, <u>is</u> salvation."[9]

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[9]Sedgwick, p. 291-295.

Dr. Paul Tillich, eminent theologian and preacher, senses the life predicament of Mary Barnes and countless others like her when he writes these words of encouragement:

> "You are accepted. You are accepted, accepted by that which is greater than you and the name of which you do not know. Do not ask for the name now; perhaps you will find it later. Do not try to do anything now, perhaps later you will do much. Do not seek for anything; do notperform anything; do not intend anything. Simply accept the fact that you are accepted."[10]

The Grace of God -- St. Paul

The underlying confidence exuded by this author came through his New Testament study of St. Paul, the Apostle, whose own life experience, like that of Mary Barnes, convinced him that God's loving forgiveness was extended to all who would receive it. It was, and is, the good news that God does not condemn, even in failure, that He loves His children and accepts them, although they do not feel acceptable.[11]

St. Paul called this the Grace of God and used the Greek word, charis, meaning joy, to describe this as "a favor freely bestowed."[12] He became the uncompromising apostle for this doctrine of grace, and taught it to be the free gift of God, in spite of sin.[13] It is giving and forgiving love, selfless, given freely, and unable to be earned.[14]

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[10]Paul Tillich, The Shaking of the Foundation (New York: Charles Scribner's Sons, 1948), p. 162.

[11]Cecil Osborne, The Art of Understanding Yourself (Grand Rapids: Zondervan, 1967), p. 119.

[12]Davis B. Harned, Grace and Common Life (Charlottesville: University Press of Virginia, 1971), p. 92.

[13]Sabapthy Kulandran, Grace in Christianity and Hinduism (London: Lutterworth Press, 1964), p. 34.

[14]Wilbur S. Howard, "Gospel According to St. John", Interpreter's Bible (Nashville:Abringdon Press, 1952), VIII, 442.

"It was something that a person could not or did not achieve, it was God's gift of grace which saved; it did not come from the person."[15] Best of all, it was not an event of the past only, but one which continues into the present.

What about the matter of sin in reference to God's forgiving love? Will God continue to forgive and accept, with no regard to quality or quantity of a person's transgressions? St. Paul is quoted in Romans 5:20 as saying, "but where sin abounded, grace did much more abound." He also affirms that God's acceptance is non conditional and limitless.[16]

Paul had been taught that if he were to please God, he was obligated to observe the long list of rigorous and demanding laws handed down through his religious tradition. The charis, or joy, for him, was the exciting discovery that the supreme law of the Scriptures and religion was love, and not morals, and that there was no need to keep straining to get in the good graces of God, who withholds his love if conditions are not just right. God is not waiting to extend forgiveness and love until a person repents; it is rather that people are incapable of accepting the grace He eternally extends until they repent. That repentance, or behavior change, is simply the way by which people bring themselves into harmoney with the pre-existent love and forgiveness of God.

To help the issue of sin and grace come into focus clearly, Tillich proposes that these words be re-interpreted in the light of today's needs; that sin does not mean an immoral act, and should not be

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[15]Ephesians 2:8-9.

[16]Romans 8:38-39.

used in the plural: that it is not our sins, but our sin which is our greatest problem, that sin is really a state of separation from God, from others, and from our own selfhood. He suggests that this is a universal fact,and the fate of every life; that we know we are estranged from something to which we really belong, and with which we should be united, and since our whole personality is involved in the alienation, it generates a sense of guilt and, consequently, the separation.[17] Rudolph Bultmann described this as a sense of separation which he stated that "sin was to be innerly divided or not to be at one with one's self."[18] Paul Johnson writes that mental illness is truly a loneliness, and a disturbed individual shuts himself off and holds up defenses to protect himself from the separation.[19]

Dr. Tillich's suggestion that grace is really acceptance was illustrated above. The Apostle Paul described the unimaginable power of grace which he experienced at the moment of his greatest separation from other people, himself, and God; it was then that he felt himself to be accepted, in spite of being rejected. When he felt accepted, he was able to accept himself, and be reconciled to others. When he could realize the forgiveness that was waiting for him to accept, he was reunited to that to which he belonged, and from which he had been estranged.[20]

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[17]Tillich, p. 154-155.

[18]Rudolph Bultmann, Theology of the New Testament (New York: Charles Scribner's Sons, 1955), p. 95.

[19]Paul Johnson, Person and Counselor (Nashville: Abingdon Press, 1967), p. 19.

[20]Tillich, p. 160.

St. Paul felt accepted and changed his life style; Mary Barnes felt accepted in the midst of her separation and loneliness, and found "salvation." When and how does this happen? Most characteristically,it comes when there is great pain and restlessness, when life seems empty and when there is a feeling of being directionless and despairing.[21]

How does it happen? Again, characteristically, the writer believes the love and forgiveness of God are channeled through human mediators. For Mary Barnes, the channels of love were Joseph Berke and members of the Kingsley Hall community. For St. Paul, the most immediate conductor of love was Ananias.[22] He says often that the grace of God is expressed through Jesus Christ. What was special about Jesus? How was he to have such a profound influence on someone who was not in his presence?

Love in Action -- Jesus

Jesus made the difference between the Old and New Testaments, but really said very little new about God. He took the traditional idea of God at its best, sloughed off the limitations, and made the love of God a revolutionary concept.[23] Inwardness and humaneness were the twin qualities of his ethic, and were based on his conviction of the supreme value of human personality. He had brought something different about

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[21]Samuel J. Mikolaski, The Grace of God (Grand Rapids: Eerdmans, 1969), p. 145.

[22]I Corinthians 15:10-11; Philippians 2:5-8; Romans 3:24.

[23]Harry Emerson Fosdick, Guide to Understanding the Bible (New York: Harper & Row, 1938), p. 134.

the nature of God into the minds and experiences of people in that first century, but it was not so much a new concept, as it was a demonstration of a love in action that centered on his determination to save persons from a life of emptiness and fear.[24] He entreated his followers to trust God and be less anxious about their temporal needs.[25] His cultural milieu was shown when he portrayed himself as a shepherd with his flock, and said, through a parable, that God cared for each one of the flock.[26] He offered help to the weary and overburdened.[27] God was for all people, ignored boundaries of race,[28] befriended the despised and outcast,[29] and admonished the people to love God, love their neighbor, and love themselves. Accepting the love and forgiveness of God was primary, and loving oneself and one's neighbor would follow. This concept of love was revolutionary, and to understand the effects of this would be very difficult. The secret of his success was in the psychic contagion of his example, the magnetic attractiveness of his life, and the cogent meanings packed into his teachings.[31] As a result of this love in motion, and Jesus' insistence that it was not he, but God, who was doing these things, the people, and then later the New Testament writers, deified Jesus; in the process God came to be described in terms of the character and attitudes of Jesus. Christ became more identified with the divine world and, no doubt, many kinds

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[24]Juan Luis Segundo, Grace and the Human Condition (Maryknoll, NY: 1973), p. 126.

[25]Matthew 6:34. [26]Matthew 12:11. [27]Matthew 11:29-31.

[28]Luke 17:11-19. [29]Luke 19:2-8 & John 4:17. [30]Matthew 6:14.

[31]Rudolph Bultmann, Kerygma and Myth (New York: Harper & Row, 1961), p. 92.

of supernatural events were linked to his ministry because of this. To be like God, then, was to be Christlike. After his death, the meekness of the Galilean ministry was somewhat forgotten, but the "grace and power" of the Lord Christ was identified with the grace and power of God, and a note of boldness grew, as his disciples became apostles, and the Jesus movement grew in strength and effectiveness.

It was for this reason that Paul, the Apostle, attributed the Grace of God as coming through Jesus Christ. Jesus was the conductor, the mediator, the channel by which God's love and forgiveness was shown to men and women in a personal way. God is Spirit[32] but His Spirit is seen best through the justice, love and compassion modeled by humans in the homes, government and market places of the world.

Grace and the Holy Spirit

The suggestion of Henry Van Duesen appeals to this writer when he proposes that the doctrines of the Grace of God and the Holy Spirit be combined into one theological composite. There is only one God, one source of energy; there are not two healing powers, personal and impersonal. Grace is not something put into the soul by the Holy Spirit. There is only one divine power, which Jesus and the disciples called the Spirit, and which can validly be referred to as grace, and still recover the Pauline point of view concerning grace, which has been a familiar terminology for nearly seventeen centuries.[33]

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[32]Harry Van Dusen, Spirit, Son and Father (New York: Charles Scribner's Sons, 1958), p. 74.

[33]Ibid.

Grace is God's forgiving love in the life of a human being. The Holy Spirit is "God's presence with us for guidance, comfort and strength."[34] To identify grace with the third person of the trinity would be more intelligible for many Christians, whose understanding of the doctrine of the Holy Spirit is traditionally thin and weak because of the influence from Augustine which made grace an impersonal deity. If one can think of grace as being synonymous with the holy spirit, the operations would be on a person-to-person basis.

Grace and Psychotherapy

Grace is not merely an idea, but an event, and is the context in which all human decision is made, whether one is aware of it or not. Growth toward authenticity may be understood as growth in the process of awareness of the grace which is present, even without that awareness. It is God Himself who bears witness within people; that in the midst of their conflicts, they are accepted by Him who wants the best for His children. "Likewise the Spirit helps us in our weakness; for we do not know how to pray as we ought but the Spirit himself intercedes for us with sighs too deep for words. And He who searches the hearts of men knows what is the mind of the Spirit."[35]

Therapy is not isolated self-help, but is always self-help in relation to another helper. The therapeutic event can become a school of repentance, a secularized confessional. But the possibility for

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[34] The United Methodist Discipline (Nashville: Methodist Publishing House, 1972).

[35] Romans 8:26-27.

repentance and knowledge of oneself as anxious, guilty, or separated from authentic life, is not found in isolation, but only as a gift of relationship.

There is a special, unique healing relationship, not common to ordinary human relationships, in the permissive atmosphere of the client therapist. The therapist shares in the reality of God's healing in the midst of his work, and he embodies that healing power. Therapeutic freedom and openness and divine grace are not synonymous, because the therapist's permission to be himself is at a particular point in history whereas divine grace is constantly renewed as eternally given in each moment.[36]

Both psychotherapy and theology share the precondition of loving others in first understanding that one is himself loved. People have difficulty in following the biblical command to love others as they love themselves, because they do not know how to love themselves authentically. As the client senses he/she is loved and cared for by the therapist, he/she finds freedom to value and care for others. "In this is love, not that we loved God but that he loved us -- if God so loved us, we also ought to love one another."[37]

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[36]Thomas C. Oden, Kergyma and Counseling (Philadelphia: Westminster Press, 1956), p. 70-73.

[37]I John 4:10-11.

CREDO FOR THE COUNSELOR

This theological investigation has given good reason to believe that, in the midst of confusion, anxiety and depression, there is a unifying potential for the mentally ill found in the religious teachings of the New Testament, particularly those of Jesus and St. Paul. There is a new awareness, even in the medical profession, that the line between the body and spirit can never be rigidly drawn, and physical ills have a close relationship to mental and spiritual states.[38] A well-thought-out faith helps to unify the inner spirit: peace of mind, inner security, calming of the fears and neurotic storms, motivation toward new interests, rising above the debilitating self-concerns and shallow miseries that keep persons locked up within themselves.[39] Dr. Paul Maves feels that the New Testament writings about the life and ministry of Jesus take for granted that there is an intimate relationship between physical, mental, moral and religious health; however, the medium of the healing power was a person, not a technique, and the needs of the sick individual were from a single need, the need for wholeness.[40]

All of this has important implications; an effective counselor approaches counseling from a particular stance or point of view. He brings himself, his basic beliefs about the world and its people into

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[38]Doniger, Simon; Religion & Health (New York: Association Press, 1958), p. 33-51.

[39]Interpreter's Bible, Mark V.

[40]Paul Maves (ed) The Church and Mental Health (New York: Charles Scribner's & Sons, 1953), p. 19.

the counseling room with him. The Christian counselor views persons from the perspective of the Christian faith, and from a Christian view of humankind. It is possible to forget this and slip into the pattern of seeing persons purely from humanistic or mechanistic points of view.[41] Psychiatric, psychological, sociological interpretations can be interesting, precise, authoritative and often helpful, but it is also possible to forget that there is an all-important point of view which is distinctive for the Christian counselor. Before proceeding to consider psychotherapeutic procedures available to the counselor dealing with the emotionally disturbed, particularly schizophrenics, it is important that some definitive guidelines be suggested for the counselor.

Each Person is a Child of God

Before an individual is a counselee, he/she is a child of God, created in His image of love, and is the object of His love. The individual is not a problem or a case, he/she is a person. No matter what one has done, how degraded, maladjusted, hostile, or resistant one may feel, he/she is first a child of God with infinite worth in this universe. Each person is a fellow human being in search of a trusted friend and/or guidance and support during a life crisis. It is important for the counselee to feel some personal connection to the universe in which one lives if he/she is to sense an inner security

[41]Charles F. Key, Pastoral Counseling Guidebook (Nashville: Abingdon Press, 1971).

that does not melt away in times of crisis or value confrontation. Vicariously, the counselee may gain inner strength and a sense of personal identity as he/she establishes a life-line relationship to a counselor who feels "at home" in the universe.

Concern for Persons

Dietrich Boenhoffer called Jesus "the man for others" who was concerned about the whole person in body, mind and spirit, and who modeled a revolutionary concept of unconditional love and acceptance in God-man and person-person relationships. For centuries the Christian Church was the chief imitator of the Good Samaritan concern for persons and that body of religious faith has been at its best when it has not tried to separate a person's soul from his total being, and has ministered to the whole person in the midst of the existential moment. The sense of separation and alienation which the counselee may feel internally, or between the person and his/her world, will be more effectively dealt with when the counselee feels that the counselor is genuinely concerned about the person and cares what happens in his/her life.

A Mediator for Love

The counselor who can be a mediator for the healing love of God to another human being will feel effective, and will be effective. There is a basic humility within the successful therapist which is a reminder that he/she is not the "healer," but only the instrument by which the healing process can happen. Energy of any kind needs a conductor if it is to be passed along for use in a different place,

or in another form. That conductor cannot take credit for the energy that passes through it, because the commodity has an original source. So it is with the healing love and acceptance which is the counselor's privilege and joy to mediate to his client. Its source is God, and the name which the Christian Church has given to this God-energy is called the Holy Spirit. Daniel Williams became very assertive when he wrote that the counselor must link himself with the Holy Spirit, if one is to minister fully to the human spirit.[42] The Holy Spirit is described as "God present with us for guidance and for strength,"[43] and the counselor's consciousness of God-at-hand and God-at-work can be a source of great reassurance in realizing that one doesn't have to play god and accept full responsibility for all the problems and all of the outcome of the therapeutic session. He/she understands God to be even more concerned about the counselee's problems that is the counselor, which means that one doesn't need to feel omniscient and will be aware of such possible feelings of discouragement, isolation or frustration.[44] This inner assurance of the presence of the Holy Spirit also makes it possible, after trust and rapport have been sufficiently established, for the counselor to speak with strength and boldness when the client is showing resistance and defensiveness that impede his progress to wholeness.

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[42]Kemp, p. 121.

[43]The United Methodist Discipline.

[44]Wayne Oates, Protestant Pastoral Counseling (Philadelphia: Westminster Press, 1962), p. 58-59.

Non-Judgmental Attitude

Developmental, analytical and environmental psychologists have shown scientifically how each of us is a product of many dynamic forces, most of which influenced us in our childhood dependency years. The counselor can honestly say about a client's situation, "There, but for the grace of God, go I." This perception helps to remove the possibility of pre judgment, prejudice, self righteousness, or scolding, and enables the counselor to stand more effectively with the client as he/she shares some personal hopes and struggles or is emotionally paralyzed by some life crisis. Knowing that someone cares, no matter what the dilemma, can be the first step of healing, and builds a bridge of understanding between counselee and counselor. God is no respecter of persons, and is not one to show partiality,[45] judge not lest you also be judged,[46] forgive,[47] be merciful.[48] It means that the counselor reaches out to the unlovely, unproductive, and the unfriendly, to love this child of God with no reservations. This does not require the therapist to condone that which seems anti-social or destructive to persons or things, but neither is there a condeming of the client who is acting out some maladaptive behavior because of a disruptive separations, fear, or hostility. Most often the counselor is the only person the client can turn to as an interested person on "neutral ground," one who can be a friend, in spite of what has happened that may be harmful, immoral, or

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[45]Luke 6:27.

[46]Matthew 7:1 [47]Luke 6:27 [48]Matthew 5:7

unloving. His/her inner self is crying out for a reconcilliation from a desperate separation and loneliness. The counselor, being a channel for God's grace (forgiving love), to be experienced through the presence of the Holy Spirit, helps the client to take the first step toward wholeness.

Truth is Relative

Paul, the Apostle asserted that a person's experiencing of God's forgiving love can set him free from the bondage of guilt and separation. This truth of God, however, is understood and applied in many different ways,as judged by the multiplicity of formal and informal religious groups that teach the Truth as they understand it. Neither the counselor nor the counselee has all the truth, and both can learn from each other. The truth to be found through the interaction of the counseling session will be relative to each individual client in his special circumstances, and particular relationships. One person's freeing revelation can be a stumbling block for another. But when the client finds the truth for and about him/herself, and discovers strength and procedures to make it applicable it can truly set that person free from the bondage of duty, obligation, or fear which has kept the joy-level at a minimum.

An Individual in the Process of Becoming

A person has the capacity to look forward and to look backward, and the present is suspended between a past from which one can become free and a future toward which he/she is moving. There are possibilities of growth, the capacity to make decisions and to respond to love. As

long as there is life, there is hope for progress and the Christian counselor continually looks for even small signs of growth of which the client often is not aware.

Mutual Experience of Separation

In using the earlier definition of sin as separation, there is a commonality which exists between counselor and counselee: both have the universal experience of separation and alienation.[49] This removes the superior-inferior, topdog-underdog relationship, since both persons stand in the need of grace and forgiveness which is available to all.

In this chapter the writer has shown how the Grace of God, His forgiveness freely given without obligation was expressed to the world through the life and teachings of Jesus Christ and the theology of St. Paul. An earlier affirmation can be restated again, that the counselor can, through the Holy Spirit, be the mediator for God's forgiving love, which is not reserved for special people or certain religious groups, but can be accepted by any who are open to receive it.

[49] Romans 3:13

CHAPTER IV

TREATMENT MODES FOR THE SCHIZOPHRENIC

In the previous chapter the writer stated that there is a growing body of practitioners in the field of mental illness who are reluctant to label an individual as schizophrenic. Since there is difficulty in diagnosis because of the many symptoms of this particular type of mental illness, there is more openness to use the term schizophrenias as an umbrella for a certain kind of psychosis.

HOSPITAL CARE AND HALFWAY HOUSE

Authorities have not found any definitive information about the cause of the illness which is described in various ways by various people. Likewise, the elimination or treatment of the condition has many variables, and requires some special conditions, not all of which have yet been specified. The implication of this is that schizophrenia requires special treatment modes, some of which have been used in the past with little productiveness; this chapter will concentrate upon those most commonly in use today by therapists in general, and by the writer, in particular. Brief reference will be made to hospitalized patients, but the bulk of the suggestions will concern out-patient treatment.

The ultimate outcome and prognosis for the schizophrenic is much more optimistic since the introduction of the phenothiazines, in 1950. Since then, it has been possible to treat nearly 50 per cent of these persons in outpatient clinics. First-time patients in hospitals

have an 80-90 per cent chance of discharge in a matter of weeks or a few months. However, readmission rate is still high, since 45 per cent of these patients return during the first year after discharge. Overall one third recover, one third have partial recovery, and one third are largely or totally disabled.[1]

Generally speaking, regardless of the treatment applied, the prognosis for recovery from schizophrenia depends on several factors:

1. Likelihood of recovery is better if the diagnosis is reactive, rather than process schizophrenia.
2. Prognosis is more favorable if there is a critical, clear and precipitating event.
3. Progress becomes poorer in ratio to the degree of withdrawal from social contact, and poor heterosexual contact.
4. A schizophrenic person with good adjust patterns of work and family before the illness is more likely to recover than others.
5. The chances for recovery are better if there are minimal pathogenic factors in the family background and the likelihood of a supportive environment to which to return.[2]

To help a person who is having difficulty in achieving basic goals in his environment, the therapist may offer help: by medication, if there is need to produce a change in the biological or chemical system of the body; by social or community or family changes, if the

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[1]James Coleman and William Broen, Jr., Abnormal Psychology and Modern Life (4th ed. Glenview, Il: Scott Foresman, 1971), p. 306.

[2]Ibid., p. 307.

environment needs to be altered; by psychotherapy, if the person needs to find a more effective way of dealing with the environment.[3]

Hospital Care

Early treatment of schizophrenia is imperative. If the illness is in its primary stages, and the person's behavior is not dangerous to himself or others, the treatment can be handled through intensive out-patient therapy. This is much preferred if the individual can continue work (even on a part-time basis), go to school, or keep up with house-keeping responsibilities. Hospitalization is recommended only if the person does not respond to chemotherapy,becomes dangerous to him/herself or others, has fantasies while driving or working, which creates risk, has incurred a possible deficiency disease through bad dietary habits, which add to the schizophrenic conditions, or if the home environment is such as to create severe stresses which the individual cannot change or tolerate. The vast majority of schizophrenics are not dangerous to others.[4]

In the event hospitalization is necessary for the protection of the patient's life or other's life, the therapist would be wise to choose the hospital in which one is most satisfied with the calibre of nurses and staff aides who work closely with the patient in milieu therapy daily. A client recently disclosed how a week-long residence in a psychiatric hospital changed his outlook on himself and life, because he felt as if he was treated like a human being who was worth

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[3]Merril T. Eaton, Jr., M.D., and Marge H. Peterson, M.D., Psychiatry (2nd ed. Flushing, NY: Medical Examination, 1969), p. 221.

[4]Ibid., p. 226.

something. We might refer to this a "Pinel's moral treatment," remembering this reformer's work in France in the 18th century, and his insistence that the hospital staff be trained to help the patient feel worthwhile in the midst of his sense of inadequacy. The schizophrenic person is very responsive to social changes, and it is natural that an institutional environment would affect the patient dramatically. The environment and atmosphere on the ward, and the length of stay in the hospital must be monitored carefully to help the patient feel that he/she is working toward some goal: probably a discharge from the hospital. A schizophrenic behavior will fluctuate dramatically in direct relationship to the kinds of interpersonal relationships experienced with the staff, who too often merely replace the dominant and withholding parent in the home environment. Regular visits by the therapist are important if the patient is not to feel neglected and unacceptable.

When the patient is ready for discharge, precise plans for the immediate continuation of outpatient treatment must be discussed with him. To provide more effective bridging of the hospital experience, and the return to the home, one or more conjoint family sessions will be necessary to provide more effective therapeutic support.[5]

Half-Way House

The term, half-way house, has come into common use in the last decade to denote a kind of residence for approximately six to eight

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[5]Professional Committee of the Schizophrenia Foundation of New Jersey, "The Schizophrenics - Yours and Mine" (Princeton, NJ: Pyramid Books, 1970), p. 66.

persons which room, board and a pseudo-family environment for those people being discharged from psychiatric hospitals but whose homes do not provide sufficient ego-support for them to return successfully;this residence is also helpful to those now residing in their homes that are dysfunctional to the point of causing mental disturbance and who would normally be hospitalized because no other facility was available. The half-way house is the midpoint between home and institution. These homes are being increasingly used by state and county agencies. Most board-and-care residences receive public assitance of some kind and are eligible for Medi-Cal treatment; this allows them treatment privileges at many mental health clinics on a regular and long-term basis.

In the treatment of the schizophrenias, there have been many treatment modes through the centuries, but in the last two decades several have been used more extensively than others, and some have been almost discarded:

1. Chemotherapy: preferred today, but less effective in long illnesses.
2. Psychotherapy: recovery depends upon the empathy and active participation of the therapist in the relationship with the patient.[6]
3. Bio-energetics: a relatively new mode of therapy, but with few qualified practitioners as yet.
4. Megavitamin: not used extensively,but has many local adherents; success depends upon body condition. More economical treatment.

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[6]Paul Mussen and Mark R. Rosenzweig, Psychology, An Introduction (Lexington, MA: Heath, 1973), p. 243.

5. Electro-convulsion: preferred to insulin coma therapy, but now largely displaced by chemotherapy.
6. Insulin Coma: not proven effective.
7. Psychoanalytic: this has been relatively ineffective, because of the person's inability to concentrate.[7]
8. Psycho-surgery: this is used when all others fail, but has lost its popularity because of risks, complications and side effects including some desirable components of personality. It is only used when the patient shows dangerous aggressive tendendies which brings suffering to himself and others.

The rest of this chapter will give a perspective of the four more commonly used therapies today: bioenergetics, megavitamin therapy, chemotherapy and psychotherapy.

BIOENERGETICS

One way of giving the schizophrenic some experience in the world of reality, is through the world of the body through bioenergetic therapy. The client senses a warmth in bioenergetic therapy which is the heat produced by the new energy flow in the tissues and musculature.

Bioenergetic activity revolves around a limited range of movements: movements or attitudes in which the unity of the body is dynamically stressed. It is only when the total organism partakes in a movement that that movement becomes emotionally expressive. It is precisely because of this inability to move in a unitary way that the schizophrenic is characteristically emotionally dull. It is important

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[7]Coleman, p. 307.

for the bioenergetic therapist to have a thorough knowledge of the dynamics of body movement, to involve the whole body in an action. It will be necessary to observe which parts of the body are held back in the action if one is to understand the nature of the block that refuses to release an appropriate emotion.

Although some notable psychotherapists, such as Carl Rogers, feel that such therapy as bioenergetics puts the therapist in the role of expert, and diminishes the client's reliance on his own inner processes,[8] this writer believes there are some long term benefits which will accrue for the schizophrenic who would enroll in a bioenergetic seminar occasionally. There is a certain enlivening that occurs which seems to give an individual a different feeling about himself.[9]

Emotional health may be defined in terms of the ability of an individual to involve the whole person in his/her actions and behavior, and an equal ability in appropriate situations to restrain actions. There is great importance in body expression as a reflection of the internal qualities. It is for this reason that this author places such physical activities as Yoga breathing and body exercises along with walking, in the bioenergetic category, because each of these exercises can be done without an expert, and still helps to provide muscular integration that also influences the emotional integration and center of being.

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[8]Raymond Corsini, (ed.) Current Psychotherapies (Itasca, Ill: Peacock, 1973), p. 128.

[9]Alexander Lowen, M.D., Language of the Body (New York: Collier Books, 1971), p. 390.

Walking[10]

The pathologically schizophrenic person often becomes the victim of his inwardness and withdrawing. He/she is distrustful of people and resists going out of the house. Consequently too much time is expended in watching television, or sleeping because of medication or boredom, and too much eating because it satisfies oral needs and soothes anxiety and restlessness. He/she becomes inactive, overweight, and body tone, appearance and sense of well-being suffers. Early in the therapy, as soon as relationship and rapport have been built sufficiently, the writer asks the person to consider his/herself-care needs for exercise and better eating habits. Many schizophrenics will follow the therapist's suggestion after a warmth and appreciation for each other has been established.

Yoga[11]

Yoga teaches physical and mental fitness, and can express a union of body, mind and soul. The practice of Yoga keeps the mind steady, helps control mental disturbances and apprehension, and helps to develop the physical balance, through breathing exercises and body postures. Yoga teaches that the mind strengthens and develops through breath control and concentration. The writer suggests this kind of exercise at home when the client is ready and appears motivated for some change in life-style and habit patterns.

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[10]See Appendix B, p. 128.

[11]See Appendix C, p. 130.

The bioenergetic activities suggested here are of a mild and controlled type, because the more lively expression of feelings through activity must be done in a rigidly controlled situation, for the schizophrenic is usually not controlled enough to handle them.

MEGAVITAMIN THERAPY

There is a strong and vocal group of therapists who feel that vitamin therapy plays an important part in the control of schizophrenia since 1941, when a symposium was held on Nutrition and Vitamin Effect on Mental Health. Principle of the theory is that there are certain substances that often are missing from the bodies of individuals, and the body and central nervous system cellular structure is not fed properly. The body cannot forget that starvation and rebels. This group of theorists believe that schizophrenics lack specific substances which upsets the chemistry balance in the body and subsequently affects the ability of the body to handle stresses. Megavitamin therapy is the nomenclature, meaning large dosages at one time. Vitamin B Complex is most used in schizophrenia treatment and the dosage varies from 3000 mg to 30,000 mg daily with acute cases. Phenothiazines and other drugs may be used until the agitation and schizophrenic symptoms are reduced or until the megavitamin threatment has done its stabilizing job.

The most difficult diagnosis presently is to distinguish between schizophrenia and Vitamin B-12 and folic acid deficiency. The onset of Vitamin B-12 deficiency can be insidious in the adult and will produce all the symptoms of the paranoid or other types of schizophrenia. When an adult develops schizophrenic symptoms for the first time it is

sometimes called paraphrenia. The target organ for a specific B-12-folate deficiency can be the brain rather than the blood which would show an anemia if this deficiency were in the blood alone. The importance of early diagnosis of the condition is important because this pseudo-schizophrenia responds well to the B-12 and folate therapy and does not respond to antiphschotic drugs. This kind of B-12 deficiency is not apt to occur as early as teenage years so the concern for first-time appearance of symptoms in the adult is warranted.

Other studies have shown also that prolonged use of Dilantin as anti-epilepsy therapy will produce a specific folic acid deficiency at ages 15-20, if Dilantin was used in early childhood years, and will show full-blown symptoms of schizophrenia. The use of an anticonvulsant to control the seizures and gentle use of small doses of folic acid and Vitamin B-12 to raise the blood levels of these two vitamins will help to remove the deficiency and minimize the schizophrenic behavior.[12]

As with any new kind of therapy this movement has its critics among those psychiatrists who have noticed no notable remission of the schizophrenic symptoms in their clients. And, since there have been researched reports showing positive results of such therapy, this will remain another of those treatments for the schizophrenic that will be placed in the category, "wait for further enlightenment."

As with any new kind of therapy this movement has its critics among those psychiatrists and others who have noticed no notable remission of the schizophrenic symptoms in their clients. A typical response is from Dr. Trotter who insists that no controlled studies

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[12]The Professional Committee...,p. 31-32.

have been accomplished to verify that the use of massive doses of B Complex alleviates schizophrenic symptoms. A recent investigative committee of the American Psychiatric Association concluded there was no scientific evidence to support megatherapy.[13]

CHEMOTHERAPY

Most researchers and practitioners today agree that stabilization of the schizophrenic personality is achieved best by chemotherapy plus psychotherapy. The therapeutic task with schizophrenic patients is an almost superhuman undertaking, but a sensitive combination of drug and dynamically oriented psychotherapy holds promise as a true therapeutic relief for those suffering from this kind of psychosis.[14]

Chemotherapy, often referred to as drugs, or medications, has revolutionized the treatment mode for schizophrenias. As was noted earlier, the number of schizophrenic patients residing in mental hospitals has dropped since 1955 by 50 per cent. The most commonly used drugs are the phenothiazines, antidepressants and anti-anxiety medications. Chlorpromazine,more commonly known as thorazine,helps to relax tensions, dissipate anxiety, without memory or attention loss, and without impairing the thought process. Anti-depressants increase alertness and interest and are used as mood elevators. To decrease apprehension and tension, and to promote better sleeping habits, the anti-anxiety drugs are prescribed. In most cases, they are used in combination, depending

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[13]Roger Trotter, McCalls 101:47, S'74.

[14]Philip R. A. May, M.D., Treatment of Schizophrenia (New York: Science House, 1968), p.42.

upon the body chemistry of the individual to tolerate the drugs, and are also adjusted for the severity of the episode. Phenothiazines may be used for several months or for several years; there is likelihood of a lifetime use for certain persons. Anti-depressant and anti-anxiety medications will probably be used for a short period, and then intermittently when intolerable stress appears once again.

Acute schizophrenia responds to heavy dosages of the medications and shows a rapid alleviation of the symptoms. The more severe and chronic episode responds more slowly, but the delusions and hallucinations will gradually be eliminated or reduced; there is a decreasing concern over "voices" and persecutors, and more interest shown in the surrounding environment.

The non physician therapist, of course, must work closely with the medical doctor or psychiatrist who prescribes the medications. A wise and considerate counselor will carefully monitor the amount of dosage each week, both for therapeutic and economic reasons. Too many medications, or inappropriate drugs, can effect grogginess and apathy in the patient, which can render him ineffective as a normally functioning person. Decreasing the dosage, after the drug has accomplished its purpose of stabilization, will allow the patient to become more alert and better able to respond emotionally to those around him. Discontinuing the medication completely is best accomplished gradually over a period of weeks, to allow the central nervous system to assume its proper supportive role.

Medication, over a longer period of time, can also encourage considerable weight gain, as the person becomes more sedentary, and the

fatty tissues in the body are not used up as readily by a metabolism system rendered lazy by the drug. Hopefully, medication can be discontinued completely as the chemotherapy and psychotherapy proceed as a unified treatment mode. The condition will still be a part of the basic makeup of the person: when stabilization of behavior has been accomplished with chemotherapy treatment, it will be important to work closely with the client in developing more effective methods for dealing with stress, disappointment and worry. "Stress of one kind or another is usually involved with the development of schizophrenia, and researchers are looking for the condition in the body mechanism which has an effect of the central nervous system's response to stress. In schizophrenia, there is some defect in the chemical machinery that prevents the body from coping with stress.[15]

The patient and therapist are faced with a dilemma: whether to realize and deal with the hate within and around the person, or to blot it out, and with it eclipse important parts of reality and mental functioning. Drugs may be beneficial in helping the patient to gradually diminish hatred or a reaction to the hatred of others, without having to pay the price which would be required if one were not medicated and more aware of reality. Psychotherapy should help to make the person more aware, rather than disguise his/her awareness,or hatred, and enable the client to become more skilled at dealing with it. This greater awareness may be what the patient is defending against. Drugs enable the blotting-out process to be selective rather than total.

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[15]Brian Inglis, Emotional Stress and Your Health (New York: Criterion Books, 1958).

There must be a team approach to the medication, alteration in family situation, and supportive relationship with the therapist.

Psychotherapy is a very important ally in this process of emotional stabilization which will be examined in the next section.

PSYCHOTHERAPY

As has been detailed in the previous chapters, persons with various mental illnesses were branded for centuries in a variety of ways and dealt with as crazy, odd, animalistic or demon-possessed; this treatment was interrupted for only brief periods of time by reforms, instituted by persons of compassion, who sensed that mental illness had its roots in societal causes more than in the supernatural or inherited. Warehousing seemed to be the only answer in the care of these unfortunates, where brutal excising was the established treatment mode administered by well-meaning persons, and generally approved by church, state and citizenry.

The Renaissance brought some independence from the supremacy of religious dogma of the Middle Ages, and allowed new ideas and new methods of learning to develop without fear of heavenly retribution; ways to understand and control physical nature began to surface in the areas of human nature as well. A humanistic and naturalistic view of human beings made it unnecessary to look upon man's widely deviant behavior patterns as a result of magic, evil spirits or punishment, or believing that recovery was a special dispensation from the gods. Rather, deviant behaviors could be viewed as susceptible to being changed by man's intelligent efforts; a new concern was shown in

understanding abnormal persons, and different methods gradually developed to cure the "insane."

Charcot used hypnosis for treatment of hysteria. Bleuler encouraged patients to talk themselves out freely and uninhibitedly to the physician. Freud, influenced by Charcot and Bleuler, explored both hypnosis and talking cure, and through experience, observation and theorizing, formulated the first extensive system for treating serious behavior disorders. His theories weren't universally successful, and a spin-off of his treatment mode brought some innovations by such people as Adler, Jung, Rank, Horney, Roberts, Dollard and Miller.

In terms of theory, some focused on heredity and others on environment as the basis of behavior disorders. Techniquewise, there was the impersonal, analytical therapist, while another type was the personal, accepting and clarifying. Some argued for a highly active and continual intervention by the therapist, others adopted a more passive role. Some felt that verbal re enactment of the primary emotional dysfunction was necessary for a change in behavior; others felt that a verbalization of current feelings toward the therapist was required. (1) Differences in length of interview series, (2) the frequency of contacts, (3) the roles to be played by therapist and patient, (4) the manner in which the relationship was defined, all presented a preponderance of decisions for the therapist who entered into a counseling relationship with his client, as this confusing mass of ideas and beliefs about psychotherapy developed. It has been remarkably unfruitful to determine which ideas, hypotheses, theories, and techniques are more sound, because no agreed-upon body of

observations has developed which all can use in deciding which of the contending ideas and beliefs have validity over the others. Each proponent uses his own polemic, rather than a controlled and systematic observation, to satisfy his ratio of success.

The practicing therapist faces a difficult dilemma, confronted by the multiplicity of behavior changes one wishes to produce in his/her patients amid a variety of theories and techniques from which to choose a treatment approach. Several criteria can be used: (1) one's own personal experience about what works or doesn't work, and what works for certain kinds of patients, (2) the experience of other therapists, although this is dangerous because the pooled judgments of experts can exert strong pressure for conformity and restrict experimentation with new procedures, (3) the prestige of an accepted procedure used by a respected therapist which also includes the same dangers as in the second criterium.

It is misleading to ask if any therapy is successful and effective. A more useful question might be: what kinds of treatment will produce what kinds of behavioral changes in what kinds of individuals?[16] Harry Stack Sullivan believes that "the therapist and patient should agree explicitly on some goals toward which they both can work. An agreement about what they will try to accomplish is a precondition to effective therapy."[17]

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[16]Donald H. Ford and Hugh B. Urban, Systems of Psychotherapy (New York: Wiley, 1963), p. 13-15.

[17]Harry Stack Sullivan, Clinical Studies in Psychiatry (New York: Norton, 1953), p. 664.

Labeling

Walter Kempler says that:

> "individual diagnostic labels are presumed to create a responsible view of the patient's symptomatic process but for one pole of a process to think it is capable of describing the other pole is most presumptious, for the therapist must filter the patient through one's own awareness and conceptual process and inevitably the diagnosis will be a therapist-filtered product."[18]

Kempler suggests that labels are like glue -- they flow on readily and must be peeled off, bit by bit. It can be confusing and frightening to the patient if he hears or sees the diagnosis.

Client's Needs

Harry Stack Sullivan, in his work with schizophrenic persons, focused on the self-esteem of the patient, and the defense he had developed to cope with his anxieties. His major objective was to correct the schizophrenic's perception of himself and others, and to realign the patient's perception and behavior so it closely approximated the norm. He devised ways of building closer and more trusting relationships with his suspicious patients,and was the first to suggest that the psychoanalyst's couch was inappropriate for the schizophrenic person because he had to be brought closer to reality.[19]

John Rosen has suggested thatthis psychosis is an interminable nightmare in which the wishes are so well disguised that the psychotic doesn't awaken. The task of the therapist is to awaken the psychotic

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[18]Ford, p. 234.

[19]Coleman, p. 280.

by unmasking the real content of the psychosis, and also puts one in the role of a loving, omnipotent protector and provider, who assumes the responsibility of bringing the patient up all over again through childhood into adulthood. The therapist also can confront the client with the absurdity of some of his/her delusions.[20]

In terms of reality testing, the patient has probably never experienced, to a great degree, a relationship that is non-critical, permissive, non judgmental and accepting of whatever one might do, feel, think, or say. If the schizophrenic person can have this kind of relationship with the therapist, a therapeutic situation will have been established, which can then help the person understand the inner self, and strengthen the ego so the defense mechanisms can be employed which are more mature, healthier and socially more acceptable than those of denial, regression and projection.[21]

Adler's concept essentially was that the patient suffers from discouragement, and the therapeutic technique lies in encouragement and an expression of faith in the client, showing no condemnation, and avoiding an overly demanding approach, which can build a sense of hope in the patient that he will be understood. Most persons seek treatment with varying degrees of hope, moving from complete hopelessness to a hope for, and an expectation of, everything, including a miracle. Because of the reality of self-fulfilling prophecy, people tend to move in the direction of their anticipations. For this reason, it is

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[20]Ibid, p. 309.

[21]Robert R. Mezer,M. D. Dynamic Psychiatry in Simple Terms (New York: Springer, 1960), p. 94.

important to keep hope elevated. If the therapy continues on a "we" basis, the patient doesn't feel alone, feels strength and security in the competency of the therapist. Some appropriate good humor in the relationship can assist in the building and retention of hope with some persons because, if one can joke, things cannot be so bad.[22]

The schizophrenic person has some very primitive and expensive ego-defenses. They cannot, and do not, unconsciously resist and have no awareness of any real resistance except as it takes form in the distrust or fear of the therapist, and a fear of therapy itself which puts them in a guarded position emotionally. Against this kind of resistance, the therapist can only offer one's sincere effort: humility and honesty.[23]

The schizophrenic has a remarkable sensitivity as a part of this missing ego-defense. Some say they respond directly to the unconscious, and can see through the therapist as quickly as a therapist sees through them. Thus, the therapist must make no pretense of being perfect, but can offer the reality of himself in the sincerity of one's effort, humility of attitude, and the honesty of conscience.[24]

Most schizophrenics demand that the therapist understand them. They live in a different but very real world. The therapist must have a sensitivity almost parallel to theirs, and, if possible,should understand their body sensations and speak intelligently about them.[25]

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[22]Corsini, p. 53.

[23]Lowen, p. 387.

[24] Ibid.

[25]Ibid.

In areas of aggressive behavior, material reality and sexual functioning, the schizophrenic is a novice; he has never fully entered into attitudes and feelings of this world, and does not trust them.

Still another suggestion is to recognize that schizophrenic patients have a distrust of others, and a difficulty in tolerating closeness in relationships. The therapist must not allow the person to spend time "practicing the symptoms" of his/her communication disorder. Keep questioning, to prevent long periods of expressing loose and symbolic language. Focus on the patient's real problems in day-to-day living: interpersonal relationships, planning for the future, rather than exploring the person's bizarre behavior.[26]

Haley reminds the therapist that the basic character of the schizophrenic, either chronic or acute, is an unwillingness to follow directions and do what he/she is told. Such a person will not refuse a request any more than he/she will firmly assent to one, but the schizophrenic typically does not do it, and does not take responsibility for refusing to do it. One may say he/she didn't hear because he/she was too preoccupied with thoughts or voices, and was too helpless and unable to move; or the client may protest that he/she misunderstood because of the delusional thoughts, and became too suspicious, too excited. Some fantastic implausible reasons may be offered for not following the request.[27]

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[26]Eaton, p. 226.

[27]Jay Haley, Strategies of Psychotherapy (New York: Grune and Stratton, 1972), p. 101.

The counselor will do well to remember that the chronic ambulatory schizophrenic does not need, or cannot absorb, intensive treatment. Any investigative therapy is contraindicated. Any efforts to explore intrapsychially can stir up inner anxiety which the patient is unable to handle without a development of more psychotic defenses. Even a strong effort to involve the patient in new activities can be detrimental. It is often best to give necessary medication, and to have therapy visits with someone who will discuss problems of his/her choice and show interest in one's well-being. This makes the difference between a good outpatient adjustment and a relapse. If the person indicates some need of help in a crisis, deal only with the crisis situation, not the chronic underlying illness. In any treatment of a chronic schizophrenic, consideration must be made to the patient's motivation for change, the degree of discomfort he/she is experiencing, and the extent to which the condition is progressing or regressing.[28]

Approaches to Individual Psychotherapies

The traditional psychoanalytic theory views the patients as sick, and in need of remedial change.[29] The innovative therapies are new, and depart from the conventional medical model of healing. They are sometimes called the third force, or humanistic-existential approach and tout a more positive view of man than the conventional therapies. Typically, these therapists see an individual as a being who is discouraged, rather than sick, and focuses the attention on

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[28]Eaton, p. 230.

[29]See Appendix E, p. 138.

immediate behavior rather than on the past, guides the individual to understand more accurately, to face reality, to fulfill one's own needs without harming him/herself or others.

Growth Model Concept of Therapy

Throughout this study we have witnessed the continual struggle that was waged through the centuries within the mental health movement pertaining to the diagnosing and treatment of mental illness: does mental illness have physical causation and should it be diagnosed and treated as a physical concern? We have also seen that mental patients were assigned to medical doctors for treatment because these practitioners were trained to bring healing to the body and there was continual assumption that mental illness, because it happened within the person, automatically had its cause in the physical body. Consequently, by and large, treatment of the mentally ill has been under the watchful eye and control of the medical profession, more recently the psychiatric doctor who brings an expertise about the physical makeup and functioning of the body into therapeutic relationship, which is a very valuable kind of knowledge to have in a counseling relationship. However, the medical model of psychotherapy assumes that an apparent problem of human behavior is a symptom of an underlying pathological condition, much as the elevation of white corpuscle count give evidence of an infection within the body. Although this model works well with physical ailments there are many practitioners who would not agree:

> "The explicit attitude or mental habit of viewing behavioral deviations as symptoms of some inner pathogenic element, which must be identified through accurate diagnosis in order to know

> "now to treat it, reflects an assumption that organic disease and psychological disorder are structurally and etiologically the same. Such an assumption is neither theoretically not experimentally defensible."[30]

Alfred North Whitehead, a great philosopher of science, wrote that this tendency to attribute all phenomena to extensions of the natural order were a vestige of medieval thought and were vulnerable to a range of unscientific weaknesses.[31] There is reason to suspect the inability of this model to provide a system for classifying and diagnosing disorders which has a respectable level of reliability and validity; also the model fails to bring an intervention approach which is effective. In an earlier chapter it was also pointed out that intrapsychic therapy is not successful with those who have the condition of schizophrenia because of inability to center in on their hurt and their emotional impoverishment. To be labeled as schizophrenic adds further estrangement to their lives and forces them further into a world of escape.

The growth model, on the otherhand,is an affirming and positive kind of therapy which builds upon a relationship between the therapist and client, encourages the counselee to share his inner feelings as being worthwhile and valid and provides a climate of hope and acceptance which will now be discussed in more detail.[32] This does not preclude

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[30]E. L. Cowen, E. A. Gardner and M. Zax (Eds.) Emergent Approaches to Mental Health Problems (New York: Appleton-Century-Crofts, 1967), p. 40-62.

[31]Richard B. Stuart, Trick or Treatment (Champaign, Il: Research Press, 1970), p. 7.

[32]Howard J. Clinebell, Jr., People Dynamics (New York: Harper & Row, 1972), p. 7-9).

an examination of intrapsychic factors which may influence interpersonal relationships but this part of the process is only a means to the ultimate end of effecting a greater harmony between the client and his environment of people and things.

Howard Clinebell proposes a therapeutic formula for growth which has become one of the third-force therapies: caring (acceptance) plus confrontation equal growth.[33] Because this growth model concept closely parallels the conclusions of this writer in Chapter III, he will use it as the model for therapy with the schizophrenic personality. The reader will recall how Mary Barnes, Jesus and St. Paul, in their respective generations and in their own way, said that growth happened when they felt accepted by both God and man. It was then that they were released to more effectively love their fellowmen.

The author of People Dynamics states that, in contrast to a sickness orientation of traditional Freudian analytical therapy and a focusing in on the negative feelings,accumulated hurts and frustration, the growth model emphasizes the healthy side of personalities and relationships and suggests working toward a set of goals, rather than trying to repair damaged areas of personalities. When a person learns to use one's own inner resources, which in some cases have been lying dormant for many years, there often is no need to dig deeper into the pathological causes of friction. Hope and acceptance practiced between two people, or in a group of people, can pull a person out of past behavioral dysfunction more easily, and often less traumatically, then a dwelling on the past can push a person to a better place.

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[33]Ibid., p. 8.

Motivations for Personal Growth

Everyone has a desire to develop himself as a person, and the counselor is challenged to awaken this drive, to be expressed positively rather than to allow it to be expressed negatively in restlessness, apathy, and the guilt/depression/anger syndrome which comes when this energy is dammed up.

This desire for growth is controlled by the quality of realtionships. The basic heart hungers for love, affirmation, freedom, pleasure, adventure and meaning are met in a caring, I-Thou relationship. Petty, shallow, manipulating and dishonesty between people blocks healthy growth. Acceptance plus confrontation equals growth.

Growth results from discovering, and affirming, who one really is, and what a person reflects as an individual, rather than reflecting and parroting what someone else is, or what is expected by someone else. This change and growth can't be forced or coerced or manipulated. Ideally, it happens when freedom in a relationship allows it to occur.

Growth is something that can happen in feelings, behavior and attitude. If it happens in one of these areas, another can be affected.

Small growth groups are the lab sessions for the art of human relationships to be developed, and provide a place to do one's own growth work; to let go of costly defenses that damage relationships.

Charles Reich describes some of the evolution occuring within persons today:

> "There is a revolution coming. It will not be like revolutions of the past. It will originate with the individual and with culture. It is now spreading with amazing rapidity ... It promises a higher reason, a more human community, a new and

> "liberated individual. Its ultimate creation will be a new enduring wholeness and beauty -- a renewed relationship of man to himself, to other men, to society, to nature and to the land."[34]

Such is the potential and the dynamics that lies behind the therapeutic growth model concept. Previously, the reader was introduced to some of the expectations and needs of the schizophrenic individual who comes out of impoverished relationships into the counselor's life. How can the therapist meet the needs of this kind of person?

The Marks of an Effective Counselor

Truax and Carkhuff have developed a highly respected monograph which outlines the dimensions of a therapist's relationship to his client: accurate empathy, non-possessive warmth and genuineness. The validity of these descriptions of the effective counselor are borne out by the manner in which they fit the expectations of the schizophrenic.

First, accurate empathy represents the therapist's attitude of "I am with you," in verbal and non-verbal language. It is not necessary to share the client's feelings, or to require that person to feel the therapist's emotion, but it is an awareness and a sensitivity to those feelings which the client may only partially reveal. The counselor will guard against intellectual interpretations, sermons, giving advice and reflecting his own experience and feelings, as a comparison to the client's feelings.

Secondly, there will be non-possessive warmth, which is an unconditional, positive regard for the client who is accepted as a person with innate human potential. It is a non-possessive caring for

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[34]Ibid., p. 13.

someone as a separate person and a willingness to share equally his/her joys and aspirations or depressions and failures. It really means a valuing of the person as an individual, separate from any evaluation of one's behavior or thoughts. It is not necessary to sanction or approve thoughts and behaviors that are disapproved by society. The counselor helps the client to search for meaning or value within that person, rather than to be burdened with disapproval or approval.

Finally, genuineness doesn't require that the therapist overtly express his/her feelings, but neither does one deny them. He/she may be actively reflecting, interpreting and analyzing as a therapist, but is at the same time, giving responses which are sincere, rather than phony, sharing real feelings rather than becoming defensive, keeping in mind that the schizophrenic is a highly perceptive person, and able, many times to read into the therapist's thoughts beyond anyone's expectations. It is not necessary, however, for the therapist to disclose one's total self.[35]

Growth Model and the Process Theory

Carl Rogers moved to the University of Wisconsin in 1957, where he instituted a set of control groups among schizophrenics in a hospital and among students and adults in the community. He tested his theory that a troubled individual is one whose self-concept has become structured in ways incongruent with his human experience; his concern was to get behind the words of the client, and into his feeling world.

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[35] C. B. Truax and R. R. Carkhuff, Toward Effective Counseling and Psychotherapy, (Chicago: Aldine, 1967).

The study of the hospitalized schizophrenic patients found that those patients whose therapists were high in the three attitudinal conditions of accurate empathy, non-possessive warmth and genuineness showed greatest gain, especially on the schizophrenic score on the MMPI. Individual positive changes were noted when the client perceived, to even a minimal degree, the genuineness, empathy and warmth of his therapist. Personality change was in the direction of being more aware of one's inner experiencing, in allowing an inner experiencing to flow and change, plus a definite change in mood and affect.

After immersing himself for several months in the recordings of numerous client-centered growth-model interviews judged successful by multiple criteria, Rogers began to note a consistent pattern of change in all the cases. Personality movement was from rigidity to flow, from stasis to changingness. From these observations, Rogers has developed his "process theory" of seven behavior strands within which behavior growth could be charted:[36]

1. Patient began with an unwillingness to communicate feelings. Personal meanings not recognized nor owned. Very rigid and close relationships felt to be dangerous.
2. Feelings then sometimes described, but an unowned past objects outself the self. May voice contradictory statement about the self on the non-self topics. Begins to show some recognition that there are some problems or conflicts, but shown as external to one's personal self.
3. Description of feelings and personal meanings begin to surface, usually unacceptable or bad in the client's eyes. Situational

[36] Corsini, p. 123-128.

events described as in the past. Freer flow of expression about him/herself as an object. Begins to recognize that existing problems are inside, not outside, the individual.

4. Feelings and personal meanings now freely described as his own. Intense feelings still not personally owned, but some dim recognition that feelings of the present may break into the open, but it is frightening. The client senses that he/she is experiencing things; there is some sense of self-responsibility for problems. There is a willing to risk occasionally, relating to others on a feeling basis.
5. Many feelings freely expressed at moment of occurrence, and experienced in immediate present, now owned and accepted. Previously denied feelings begin to bubble through to the surface, but still some fear of this. Recognizes that some contradictions exist in different parts of his/her personality. "My mind seems to tell me this, but I don't believe it," is a typical reaction. There is a desire to be the "real me." Acknowledges a responsibility for problems.
6. Feelings previously denied now experienced in present and accepted, with no denial, fear or struggle. Experiencing often vivid, dramatic and releasing. Accepts the experiencing as a way to get to the root meaning of an encounter with the inner self and with life. Still not much awareness of self as an object. Feels somewhat shaky about the change occurring. Risks being honest in peer relationships and trusting others to accept him/her.

7. Individual now rises to the level of living comfortably in the fluidity of experiencing. Feelings experienced with richness and immediacy. Inner experiencing is clear resource for behavior. Incongruence is minimal and temporary. Self is confident of the process.[37]

This study is a clear and outstanding demonstration of the validity, and almost miraculous, effectiveness of the growth model therapeutic theory. It parallels very closely the experience of Mary Barnes, who went through several stages of growth in her journey up from the depths of confusion and despondency, to a fully functioning human being. Acceptance (caring) plus confrontation equals growth.

Growth Model, Process Theory and a Private Client

The reader is referred to the case study of John S.,as detailed fully elsewhere.[38] My experience with John and other schizophrenics with whom I have worked for two years has shown that the growth model concept works with satisfying results. As the treatment plan is reviewed with these persons, several ingredients are included in each case:

1. Several sessions are used to establish a warmth and friendship, with conversation at the pace and level desired by the client. Good humor is also included when the client appears ready for it.

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[37] Ibid., p. 123-128.

[38] See Appendix D, p. 133.

2. I try to help the person know that he/she is important to me, that I like him/her. I make certain that my greetings and farewells are warm and genuine.
3. At an appropriate time I reach out with a physical touch, through a handshake, hand on the shoulder, and later, perhaps, an embrace if appropriate. I would like the person to know one can be touched without any personal hurt. This kind of closeness would be person-specific and not a general procedure.
4. Most of the clients are sedentary and stay in the house a great deal. I encourage them first, to take a brisk daily walk, beginning with 15 minutes and then increasing up to one hour.
5. As soon as the person seems ready for another step, he/she is encouraged to socialize by going to the show, bowling, or attending a public concert, etc. If the person has not been able to do so before, I suggest that he/she go to the shopping center once daily to get a paper or to do some shopping, no matter how little.
6. If responsibilities have been a problem because of lack of concentration, propensity for distraction, or lack of motivation, the individual will be asked to contract with me to cook a meal weekly, shop once a week, clean a closet, etc. If the person can do one thing a week to begin with, that usually is the beginning of treatment success.
7. When sufficient confidence and motivation have been gained, the client is offered a chance to find an outlet for his/her energies: vocational school in a sheltered workshop setting,

part-time if there is a skill already, volunteer in an area of interest. (One middle-aged woman, never married, but secretly missing the experience of motherhood, is now working two days a week in the county hospital children's ward, and commutes on the bus alone. Two years ago she was just out of the hospital and hardly able to navigate.)

Thus the growth model concept of the psychotherapy calls upon a wide range of ongoing inner dynamics of the therapist and the client. The interaction of two persons growing out of their own inner being becomes the dynamic of the therapeutic relationship. The focus is on the direct experiencing in the relationship. Much emphasis is upon process as well as the content.

Reduction of Stress

One of the features of the chemotherapy - talk-therapy method is the gradual discovery of the stress factors in the individual's life and how to adapt to these stresses or to change life-style sufficiently to eliminate the stresses. The above suggestions have related to persons who are in the first throes of this discovery.

For those schizophrenic persons whose symptoms have come under manageable control there is continual need to monitor the stress level and find ways of diminishing it, such as:

Changing to an occupation with less pressure to compete on a daily basis for hard-to-reach goals and with minimal schedule limitations.

Limiting work hours to the time of day when the body and mind are more alert and productive or schedule into the day a time for relaxation, meditation or exercise that interrupts the stress condition.

Eliminate long commute to work if the travel produces mind and body constricture and a sense of anxiety.

Sleep is very important ingredient for the stress-prone person. Resting in mid-day, without sleep, will relax the body and mind sufficiently to handle the balance of the day without undue stress.

Body massage helps to relax both the body and mind. The person who does not live alone would benefit substantially by suggesting a brief introductory course in body massage for his house partner who would then be able to administer this kind of therapy on a daily basis.

Many people gain respite from stress by occasionally going to the ocean and absorb the calming effect of the rolling waves coming on shore. Similarly, a trip into the high hills or mountains for a day helps many individuals to gain better perspective of themselves by looking down on their world of confusion and demands instead of their usual position in the midst of it all and often feeling burdened down by it.

Relatives and friends can be of great assistance in resisting the temptation to be overly argumentative or insisting that peculiar habits must be corrected or certain complexes must be talked out completely. Again, the matter of acceptance is the key.

A LOOK INTO THE FUTURE

This study of the treatment of the mentally ill has shown the inconceivable neglect and cruelty which society has put upon this segment of our society. The rise and fall of reform movements has been an awesome picture to absorb, yet we are experiencing the same fluctuation in our own generation. Several progressive movements in the area of hospital care, out-patient treatment, chemotherapy and legislation affecting the mentally ill were welcomed during this last decade. With the most recent national concerns about inflation and recession the budgets of local, state and federal governments too often find their economies in the areas of health, education and welfare. Consequently several agencies, both private and public, have drastically curtailed research and therapy programs that have both preventative and therapeutic concerns.

The research effort in schizophrenia is minimal when compared to the massive toll it takes annually. Voluntary contributions to heart disease funds totaled 34 million in 1965, while the whole field of mental health collected only 8 million of charitable dollars. Of this one-third of the heart fund was used in research while only one-sixteenth was allocated for mental health research.

Some of the areas of research in schizophrenia which are awaiting funding and interest from both professional and laymen will be of interest:

1. Developing a series of diagnostic tests to detect early schizophrenia which would be made available to high school and college counselors. These would include pyschometrics, brain wave, blood, skin, saliva and urine tests.
2. More definitive data is needed to determine the pros and cons of megavitamin therapy and other biochemical therapy.
3. To learn more about schizophrenic families and their biochemical constitution.
4. More understanding is needed about the allergic capabilities of schizophrenic persons.
5. To make a concentrated study of those people who contact schizophrenia for only brief periods of each year.
6. To discover the reasons for schizophrenic characteristics in postpartum psychosis and hypothyroid psychosis.
7. To find the cause for overstimulation of the brain in schizophrenic persons.

8. To understand better how the various anti-schizophrenic drugs work in the body.[39]

Mental health is a univeral problem. Management of it has gone through some changes and the problems to be solved are immense and staggering: training of nurses, therapists and social workers. There is a need for more psychiatric wings in hospitals and clinics, but mostly it would be important to see the need for education of the general population regarding mental illness.

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[39]The Professional Committee..., p. 15.

CONCLUSIONS

This study has traced the evolution in the understanding and treatment of a mental illness known as schizophrenia which is one of the most baffling and elusive challenges facing the mental health field today. The evolution of the understanding and treatment of schizophrenia was traced briefly through the pages of recorded history to show how the prevailing attitude toward the mentally ill has been generally one of hatred, fear and rejection. In almost every era there were men and women who rose above this negative perception with a compassion and acceptance that brought brief respite for the mentally ill; unfortunately, it seemed that after one step in progress was taken, two steps in regression came soon after. Considerable progress came in the 19th century when mental illness was placed on a nearly equal basis with physical illness in medical circles and extensive research showed that psychosocial influences were important in generating mental illness; however, the 20th century produced a breakthrough in the use of sedatives and tranquilizing drugs which brought about a major change in the treatment of schizophrenia and other psychoses; 50 per cent of hospitalized patients have been released to outpatient care and have been able to find more fulfillment in their lives.

No one clinical entity can be isolated as the cause of schizophrenia; studies indicate a mixture of organic and psychological factors are involved. Procedure in diagnosis is changing to reflect the gradual evolution from intrapsychic to psychosocial and interpersonal behavior influences in the stress-producing phenomena of

schizophrenia. This does not mean the denial of the condition of schizophrenia but represents a refusal to label it under the medical model and to build treatment around that concept of biological illness.

Several case studies of recovered schizophrenics have shown the emotional impoverishment they have experienced as individuals -- the lack of acceptance as a person, little self-worth and a feeling that they were not at home in the world. Our study of the New Testament theology of Paul, the Apostle, and the life and teachings of Jesus emphasizes the free gift of love and forgiveness from God -- a basic acceptance of an individual in spite of past failures. When a person feels accepted by God, one is then more able to accept him/herself as worthwhile and to feel accepted by other human beings.

The counselor-therapist who is aware of his/her own need to be related to the Ground of Being and who possesses empathy, warmth and genuineness is one who is most able to be the mediator of acceptance, love and forgiveness to a schizophrenic person whose sense of rejection, fear and hopelessness is so intense.

In extreme cases hospitalization may be necessary to remove the client from a disturbing environment until that person can be stabilized emotionally. Although many kinds of treatment are being developed today the combination of chemotherapy and psychotherapy is bringing more symptom-relief. The half-way house is also increasingly recommended for individuals who have been hospitalized and cannot be discharged into a dysfunctional home relationship; this board-and-care residence plan under state registration but operated by trained, private individuals

is available also to those who need relief from a stress-producing environment and who would be a likely candidate for hospitalization otherwise.

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APPENDIXES

APPENDIX A

THE ART OF BEING SCHIZOPHRENIC*

To be schizophrenic, it is essential that one be born into the right sort of family, and if one can manage that, all else may follow. As individuals, the family members are unrecognizable on the street, but together, the outstanding feature is apparent -- a kind of formless, bizarre despair overlaid with a veneer of glossy hope and good intentions, concealing a power-struggle-to-the-death -- coated with a quality of continual confusion. The schizophrenic learns from his mother how to maneuver in interpersonal relations; she must have a range of behavior unequalled, except by the most accomplished of actresses. Capable of weeping when crossed, promising violence, expressing concern, threatening to go mad and fall apart, being kind and pious, offering to leave if another word is said. She can pass blame for her behavior to others. These mothers don't represent more than 20 per cent of the females born.

To balance the flexibility of this mother, the schizophrenic must have a father who will teach him to remain immovable. The father has a stubborness unequalled among men (as well as the skill to keep a woman in a state of exasperated despair, which helps her to make use of her full range of behavior). The incidence of schizophrenia could not be too high, because it is not easy to get such an uncommon man and uncommon woman together.

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*Adapted from Jay Haley, "The Art of Being Schizophrenic" (Source unknown).

Finally, it is important that the schizophrenic have in his environment a brother or sister who is the kind of person who is hated on contact -- a do-gooder --, a good-in-schooler, sweet, weak, kind bastard of a sibling who can provide contrast for the future schizophrenic, by showing him up to be the complete idiot his family expects him to be.

It is the primary function of the schizophrenic to be the representative failure in the family, and in that sense, be remarkable. The parents feel themselves to be lost souls, incapable of any human accomplishment, and their survival depends on the terrible failure they see in the child, because it lets them stand a little higher in the world. The schizophrenic will achieve at intervals, to give the parents reason for admiration, but allowing them sufficient cause for disappointment.

The schizophrenic child is usually caught up, not only in the conflict between his parents, but is in the middle of the triangular struggle between the mother and her mother, the father and his mother and other cross-generational relationships in the family. The schizophrenic has had a lifetime of balancing conflicting family triangles, each one focused on his every action. He must learn to communicate among the many factions of the family in a way that satisfies everyone, by saying one thing and disqualifying it with a conflicting statement, and indicating that he didn't mean it anyhow. He soon learns that he has a position of extreme power in manipulating triangles to his advantage.

The primary responsibility of the schizophrenic is to hold the family together. His importance is shown, when on rare occasions the

schizophrenic abandons his disease and becomes normal, succeeding in life and leaving his family home. The parents at once individually collapse and divorce. The schizophrenic child prevents divorce, and family dissolution in a simple way: he provides the parents an excuse for staying together by offering himself as a problem, and looking unhappy when mother and father make minor threats of separation. If parents threaten to come closer together and be more affectionate, and make a change in the family, the schizophrenic child will say or do something to cause the parents to war against each other.

APPENDIX B

WALKING*

Exercise must be regular and proper to avoid harmful effects of doing too much too soon. Physician's advice is important before beginning. For most people, the following guidelines are helpful:

1. Begin walking at a comfortable speed, 10 minutes daily.
2. Slowly and gradually increase that speed well within your own limits.
3. Do not walk at a speed where resulting fatigue cannot be relieved by a few minutes' rest.
4. Gradually increase speed to rate of one mile in 20 minutes. Walking time can be expanded by degrees to cover three miles in an hour.
5. Again, gradually increase speed to three miles in 45 minutes.

Don't set up too many rules. Rigidity drives people to stop exercise too often. If the weather is bad, don't feel guilty about not walking; nor feel compelled to walk twice as much the next day to pay a debt.

Arrange walking to accomplish a purpose. Walk the dog, walk to the store to do shopping, walk to a specific destination.

Be aware and alert while walking. Greet persons (probable of the same sex), and exchange "good morning." Notice flowers, homes, singing of the birds, little children on the way to school. Breathe deeply and find positive environmental items to feel good about.

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*Los Angeles County Heart Association, Los Angeles, Ca., 90057.

Walk with a family member or a neighbor or a friend. Conversation can make the walk seem much pleasanter and faster.

APPENDIX C

YOGA*

Practiced as early as 4000 B.C. .. It is not a religion.

Yoga means "union;" union of mind, soul and body. Brought about by the process of body culture, breath control (which gives mind control), and applied psychology. Yoga practice keeps the mind steady, prevents mental disturbances and apprehension. Hatha Yoga develops the physical balance through breathing exercises and body postures. The mind strengthens and develops through break control and concentration.

Life Force and Breath

When God created man, he breathed over him and gave him life. This life force is obtained from the sun and is used to maintain the body and all other living things. The way we breathe determines the amount of life force we can receive and retain. The more life force we can retain, the more vitality we will have. Controlling the breath helps to achieve better health, more energy and a good complexion; calms the mind and improves concentration.

Complete and perfect Yoga breath: "this breath fills the lower, middle and upper part of the lungs," in that order. Exhale completely, then breathe in so that the abdomen moves outward. Lower ribs should then rise. Breathing should be done through the nose only, in smooth, rhythmic way. While inhaling, count four, hold for count of two while exhaling, count to four, then hold for two counts before

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*"Yoga Center," Fresno, Ca.

exhaling. After exertion, or while deep-breathing, a longer count may be used. Through the practice of controlled breathing, the normal breath will become deeper and much slower. Slower breathing will relax the mind, because the pulse of the brain is controlled by the breath.

Stomach Lift

One of the most important exercises because it tones and stimulates the entire abdominal area, including stomach, liver, spleen intestinal tract and colon. Two most important benefits are improved digestion, and better elimination. To have a clear mind, it is necessary to have a clear colon. For women, the stomach lift also tones and stimulates the ovaries, uterus, and the complete reproductive system. It should be done on an empty stomach. Best in the early morning. "Stand with the feet approximately 12 inches apart, with the knees slightly bent, hands resting on the upper thighs. In this semi-squatting position, exhale completely, and without breathing, draw in the stomach and raise the diaphragm as high as possible. Still holding the breath, relax the diaphragm and stomach muscles and then draw them up again; do this once, twice, or as many times as you can do comfortably. Inhale and relax a few seconds before repeating."

Back Handclasp

Relaxes muscles of upper back, neck and shoulders. Improves the posture, firms the upper arm. Good before going to sleep, or anytime to relieve tension of upper back and neck muscles. "Reach over

"the right shoulder with the right hand, so hand is on the spine. Left arm is bent behind you, placing the hand on the spine palm out. Push and wiggle the left hand up, and the right hand down until they touch, clasp the fingers and pull. Keeping the head erect, hold the tension a few seconds, release, then clasp slowly; lower the arms, reverse the position of the hands and arms and repeat. A few seconds may be added each week until you are holding the position for 30 seconds."

Rocking Chair

A few minutes of gentle stretching massage is helpful too. It massages the vertebrae muscles and nerve centers along the spine and back. "Sit on the floor and raise your knees, leaving feet on the floor and place hands in the fold of the legs under the knees. Bend the head forward, breathing through the nose, exhaling as you rock back, and inhaling as you rock forward to the original position. Repeat ten times or more."

Make these as the beginning, and create the habit of practicing Yoga positions every day. Take it slowly, the chemistry of the body will start to change from the first day that practice begins. Often you are more calm and have a general feeling of well-being.

APPENDIX D

CASE STUDY

John S. is a 28-year-old, Caucasian, overweight male. He was brought to the private clinic by his mother, just after his discharge from the psychiatric ward of a hospital in a neighboring community. He was notably non-verbal, had blunted affect, clearly dependent upon his mother, and anxiously afraid. I accepted him as my client, seeing him twice weekly initially, for about three months, and then once weekly. Our first month relationship consisted mainly in establishing a friendship. Conversation consisted mostly of a question from me and an answer of one word, or perhaps a short sentence. I asked his mother to come on jointly and individually several times, since I sensed a strong symbiotic relationship; she acknowledged some over-protectiveness and over-sheltering as a result of her worry about him when he was precariously ill after birth: the doctor said John had had some brain damage and would be retarded.

At the beginning, she denied any unusual over-sheltering, but recanted later when also confronted by her husband, who had evidently felt that, as I; but did not feel, as John's stepfather, that he should raise the issue of his wife's love for the boy. John also expressed, with feeling, that he was placed in the "dumb class" at school where he didn't learn very much, even though he acknowledged it was difficult for him to learn in the regular classes. (He was saying that he was ready to learn more than anyone thought.) He said that the teachers didn't spend much time with him, and he learned few

skills in reading and writing. There were few opportunities for him to be around girls, because "they put all the good-looking ones in the regular class, no matter what."

He grew to this age without having a single date, although he used to chase the girls in his car, and evidently was obnoxious enough for one girl to call the police. After about four sessions, he laughed for the first time, and after six sessions, he called me by my first name (which I encourage all my clients to do). Physical closeness began with a handshake, at my instigation, then to a hand on the shoulder, and then an embrace. We did not talk in depth, except for' his recounting of his work history and hospital life. Then we talked about his natural father, and the divorce which preceding his break-down, then to his mother's super-worry over him, and then girls.

Another of my clients was a girl somewhat younger, but who had an impoverished childhood, and a similar traumatic experience through a difficult marriage. With his permission, I asked her to join us as the beginning of a small group. Herintelligence level was higher, but her maturity was about the same as John's. He began to take her home, to bring her, and then, after we two had talked about it, he asked her to the show. She was highly manipulative, he was naive, and his mother got worried about her boy being taken advantage of. I asked the mother to let us work on it together. We learned about the emotions of women, and of this particular emotionally starved young lady. He began to show assertiveness, to show less anxiety, and to be less worried about how he "might hurt her feelings if he said 'no'." (His mother is, admittedly, a very sensitive woman, whose feelings are easily hurt.)

John and the young lady attended a larger group with other young people now, and last week John surprised the group by giving quite a lengthy discourse about how his girl friend was mad because he wouldn't let her use the car -- but he didn't lose any sleep about it, and the mother is letting him work it out. He is about to enter a vocational school, and is interested now in attending a workshop on intimacy, to learn better how to relate to the opposite sex. We talked this week about his desire to learn; he wants to receive remedial tutoring. I consider him to be my very good friend - his mother says he considers me to be his best friend - a first-hand example of how a counselor can, if he wishes, be mediator for, acceptance and caring in such a way that growth can occur so dramatically in such a short time. Also, because one of the girls in the group indicated that he would be more attractive with some weight loss, he has lost 35 pounds of weight.

Circumstances at the clinic made it possible for John to be tested with a battery of psychometric tests, the first about six months after his enrollment and the second about three months later, at about the time when he was opening himself and his feelings. Following are excerpts taken from the psychologist's report. The tests administered were the Wexler Adult Intelligence Scale (WAIS), picture completion, objective assembly task, block design subtests, Graham-Kendall Memory for Design test and the Bender-Gestalt.

First Testing, December, 1974

John S. referred after having "nervous breakdown" several years after graduation from high school. He was able to provide only the barest of details. Had fairly good premorbid work history, from sweeper in a dog-pound to a commissary clerk at $3 hourly. Lived with brother and sister-in-law. Mother and father divorced when he was a young child; mother, John, and older brother moved to California. Mother remarried three years ago, which may have precipitated psychotic break. He had no peer relationships. Spent his money on automobiles and models. Kept to himself, living in a room annexed to his brother's house. The only significant relationship was his mother, and, to a lesser degree, his brother. Presently assists mother in managing apartment house complex. Spends his free time riding a 10-speed bike.

He is seen as a chronic paranoid schizophrenic. Separated from his outer environment, and invests energy in his own fantasies and auto-erotic acts. His affect is generally bland. Emotional stimulation raises considerable anxiety; he fears destruction by involvement with others. Fears of destruction via intimacy comes from his own powerful urges for clinging in symbiotic closeness to others. He projects these wishes to others, and fears he will be stifled which is a chronic problem. Prognosis for recovery of function at previous level before breakdown is extremely guarded.

Second Test, March, 1975

Client appeared as paranoid schizophrenic with decreased efficiency and intellectual functioning. Verbal IQ was 70, now 73; performance IQ was 82, now 85; full scale was 74, now 77. MMPI shows confused thinking and testing indicates organic difficulty. However, the general picture is one of mild improvement. The intellect is about the same, but there is a definite increase in self-confidence. There is an increased ability to censure out and suppress inappropriate associations. The possibility of human relations appears to be more appealing, but still generally unable to handle emotional stimulation well. Appears somewhat more relaxed in defense rigidity. While IQ appears nearly the same, there has been some definite improvement in the level of reality testing. Overall, he seems notably improved. John seems to be having difficulty in relation to his parents; peer relationships seem more attractive then formerly. Thus, though he is in some distress, he appears to be handling it well, in the light of his abilities. Treatment is recommended on a long term basis, with a further evaluation in one year.

APPENDIX E

TRADITIONAL APPROACHES TO INDIVIDUAL PSYCHOTHERAPIES

Psychoanalysis (Sigmund Freud)

Designed to help the individual gain a conscious access to his repressed self so that his miseries, conflicts and anxieties can be diminished. Focuses on childhood relationships where roots of pathology are found, helps to understand emotionally what happened to disturb the emotional system. Uses free association, dream analysis, transference and interpretation.

Developmental Theory (Erik Erickson)

There is neo-Freudian and uses eight stages of ego development, similar to Freud's psychosexual stages. Suggests that failures and successes at each stage result in corresponding psychological states. Finding one's identity involves the complex process of integrating all of the identifications a person has made during his first 12-20 years of development. This makes for a popular reception on college campuses. The mentally healthy individual is one whose childhood anxities persist into adulthood and lead to the undermining of adult security and identity, attended by mistrust, shame, doubt, guilt, inferiority, role confusion, isolation, stagnation and despair.

Analytical Psychology (Carl Jung)

Jung is a contemporary of Freud but parted company from him by de-emphasizing sexuality as a central theme and focused more on the mystical. The defined the self as a striving toward an idealpersonality which is not the real person but rather a motivating force that constantly undergoes modification by the person's conscious and unconscious experiences. The libido is considered a life-energy that originated from the body's processes and which forces a person's expression in two ways: inner-oriented introvertive, subjective personal experiences and outgoing extrovertive expression concerned with objects and people. Uses interpretation of dreams, fantasies and artistic productions to uncover complexes. Placed much emphasis on what the person claims to be important in the dream. Each person holds the key to deciphering or decoding his own text but the therapist interprets the symbolism of the dream. He feels we all emerge from a deeply unconscious world of which we still contain traces that show up in dreams.

Individual Psychology (Alfred Adler)

Adler is a contemporary of Freud and a close worker but broke away from Freud's close tutelage. He differs from Freud, Erickson and Jung's instinctual models by insisting that man is motivated primarily by social urges; human beings are social beings who relate to other people, engage in cooperative social activities and place social welfare above selfish interests. He has three therapeutic objectives: to understand the lifestyle of the individual, the problem situation

and the meaning of symptoms; explains the client to himself by communicating effectively; strengthens the client's social interest by giving him the experience of a "fellowman" and cooperation in a joint task of treatment. Adlerians are not reluctant to give advice, and will lay down a set of rules for living and strongly advise the patient to follow them; there is little time-lapse before explaining to the client the connection between symptoms and early and current behaviors.

Neo-Analytic (Erich Fromm)

Like Adler and Jung, Fromm was dissatisfied with Freud's personality theory, particularly that of the libido. Like Adler, he believed that man's relatedness to the world is more important than his sexuality. He emphasized that man feels lonely and isolated because he has become separated from nature and from other people. Abnormal people are ones who have not learned to cope adequately with the demands of society but society makes abnormal demands which are contrary to a person's nature. Man would like to escape from society and he uses neurotic mechanisms as masochism, sadism and destructiveness, as well as automation conformity. He straddles the line between the traditional and humanistic therapies.

APPENDIX F

STATISTICS FOR 1960

The schizophrenias lead both general diseases and mental disease as the cause of hospitalization. Since only one-third of the patients are hospitalized it is, the world's greatest disease.

Diagnoses on patients with mental illness who were in a hospital in the United States are as follows for the year 1960:

Schizophrenia	23.0 %	
Alcoholism	14.6 %	One-fourth are basically schizophrenic
Personality disorders	7.3 %	Diagnosis?
Psychoneurotic reactions	6.9 %	Diagnosis?
Mental deficiency	3.0 %	
Epilepsy, Parkinsonism,etc.	13.9 %	
Senility, brain damage,etc.	23.0 %	
Other psychotic disorders	8.3 %	
	100.0 %	